September 16, 2015

John J. Dreyzehner, MD, MPH, FACOEM
Commissioner, Tennessee Department of Health
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Dear Commissioner Dreyzehner,

This letter will serve as notice to the Department, and to the state officials copied on this letter, of the intent of Mountain States Health Alliance ("Mountain States") and Wellmont Health System ("Wellmont") (collectively, the "Parties") to file an application for the issuance of a Certificate of Public Advantage ("COPA") with respect to a cooperative agreement. Under this cooperative agreement, a new parent entity will be created that will become the sole member of both Mountain States and Wellmont. This letter of intent is submitted on behalf of both Mountain States and Wellmont.

This letter is submitted pursuant to the emergency rules promulgated recently as Tennessee Rules Chapter 1200-38-01-.01 et seq.

Each element required by the Tennessee emergency rules to be included in this letter of intent is addressed below.

1. A brief description of the proposed Cooperative Agreement, including the physical location of the entities and parties to the Cooperative Agreement

   The proposed Cooperative Agreement will be titled the "Master Affiliation Agreement and Plan of Integration." At this time, Wellmont and Mountain States have signed a non-binding term sheet. The Parties are completing negotiation of the Cooperative Agreement and conducting due diligence. The Parties intend to sign the proposed Cooperative Agreement prior to the filing of the COPA Application.

   Pursuant to the Cooperative Agreement, the Parties will cause a new, independent public benefit not for profit, tax-exempt corporation to be incorporated in Tennessee (the "Parent Entity"). The Parent Entity will be governed by a self-perpetuating Board of Directors. The Parties will amend their respective articles and bylaws to designate the Parent Entity as the sole corporate member of each of the Parties.

   Wellmont operates six hospitals and numerous outpatient care sites, primarily serving communities in Northeast Tennessee and Southwest Virginia. Wellmont's corporate offices are located at 1905 American Way, Kingsport, Tennessee 37660.

Mountain States operates thirteen hospitals and numerous outpatient care sites across a twenty-nine county, four-state region. Mountain States' corporate offices are located at 303 Med Tech Parkway, Suite 300, Johnson City, Tennessee 37604.

2. A list that includes the assets, ownership interests, subsidiaries and affiliated businesses currently owned or operated, in whole or in part, directly or indirectly, by any party to the Cooperative Agreement that the parties propose to be included in the COPA or any assets, ownership interests, subsidiaries and affiliated businesses currently owned or operated, in whole or part, by any party to the Cooperative Agreement that will be divested, sold or affected as a result of the Cooperative Agreement

   The Parties intend for the Cooperative Agreement to include all assets, ownership interest, subsidiaries and controlled affiliated businesses currently owned or operated, in whole or in part, directly or indirectly, by the respective Parties, and none are intended to be divested, sold or otherwise affected as a result of the Cooperative Agreement. An organizational chart identifying all of the subsidiaries and affiliates of Mountain States is attached as Exhibit A. An organizational chart identifying all of the subsidiaries and affiliates of Wellmont is attached as Exhibit B.

3. A list of business interests or units for which each party to the Cooperative Agreement has any ownership interest or a management contract that is not proposed to be included in the Cooperative Agreement

   See response to item 2 above.

4. The name, address and contact information of the parties to the proposed Cooperative Agreement including the executive officers, each party's respective board members and each party's general counsel

Mountain States Health Alliance
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604

Mountain States Executive Officers
- Alan Levine, President & CEO
- Marvin Eichorn, Executive Vice President and Chief Operating Officer
- Lynn Krutak, Senior Vice President/Chief Financial Officer
- Tim Belisle, Senior Vice President-Compliance Officer and General Counsel

Wellmont Health System
1905 American Way
Kingsport, Tennessee 37660

Wellmont Executive Officers
- Bart Hove, President & CEO
- Eric Deaton, Executive Vice President and Chief Operating Officer
- Alice Pope, Executive Vice President and Chief Financial Officer
- Gary Miller, Senior Vice President, Legal Affairs, and General Counsel

Mountain States Board Members

- Barbara Allen, Chair
- Bob Feathers, Vice Chair
- Joanne Gilmer, Secretary
- Michael Christian, Treasurer
- Clem Wilkes, Jr., Past Chair
- Alan Levine
- David May, MD
- Gary Peacock
- Jeff Farrow, MD
- Linda Garceau
- Rick Storey
- Sandra Brooks, MD

Wellmont Board Members

- Roger Leonard, Chair
- Julie Bennett, Vice Chair
- Wayne Kennedy, Secretary
- Roger Mowen, Treasurer
- Terry Begley
- R. David Crockett Sr.
- Dr. Stan Gall
- Dr. D. Nelson Gwaltney
- Mary Dean Hall
- Ravan Krickbaum
- David Lester
- Glen "Skip" Skinner
- Dr. William Smith
- Dr. David Sparks
- Dr. Doug Springer
- Dr. David Thompson
- Keith Wilson
- Ted Wood

5. A description of the entities' governing structure under the Cooperative Agreement

The Parent Entity will be led by a board of directors and a management team composed of current executives from both organizations. The board of directors of the Parent Entity will be comprised of fourteen (14) voting members, as well as two (2) ex-officio voting members and one (1) ex-officio non-voting member. Wellmont and Mountain States will each designate six (6) members to serve on the initial board of the Parent Entity. Wellmont and Mountain States will jointly select two (2) members of the initial Parent Entity board, who will not be incumbent members of either Party's board of directors. The two ex-officio voting members will be the Parent Entity Executive Chairman/President and the Parent Entity Chief Executive Officer. The ex-officio non-voting member will be the then current President of East Tennessee State University. The new organization will be managed by an executive team with representatives from each organization serving in the following agreed upon roles—Executive Chairman/President Alan Levine, CEO Bart Hove, COO Marvin Eichorn and CFO Alice Pope. Other senior management positions will be determined at a later date.

6. The anticipated date of submission of the Application; and the anticipated effective date of the proposed Cooperative Agreement

   The Parties anticipate filing the Application on or about November 1, 2015. At this time, the Parties anticipate that the effective date of the proposed Cooperative Agreement will be on or about November 1, 2015 (projected).

7. The geographic service area and Population covered by the Cooperative Agreement

   The geographic service area covered by the Cooperative Agreement is expected to include the following counties: Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee; Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina; Harlan and Letcher in Kentucky, and Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe in Virginia. The Population covered by the Cooperative Agreement is expected to include the entirety of the human population residing or domiciled in this geographic service area.

We would be happy to discuss any of this information or any questions that you, or your staff, may have. Please direct any questions you may have to Mountain States' representative, Dick Lodge at dlodge@bassberry.com and to Wellmont's representative, Dick Cowart at dcowart@bakerdonelson.com. We look forward to submitting our formal Application soon.

Sincerely,

Mountain States Health Alliance
Board Chair

Barbara Allen

Wellmont Health System
Board Chair

Roger Leonard

Mountain States Health Alliance
President &
Chief Executive Officer

Alan Levine

Wellmont Health System
President &
Chief Executive Officer

Bart Hove

cc: Vic Domen
Jane Young
J. Richard Lodge
Richard G. Cowart

Exhibit A

See attached.

Mountain States Health Alliance

Legal Structure

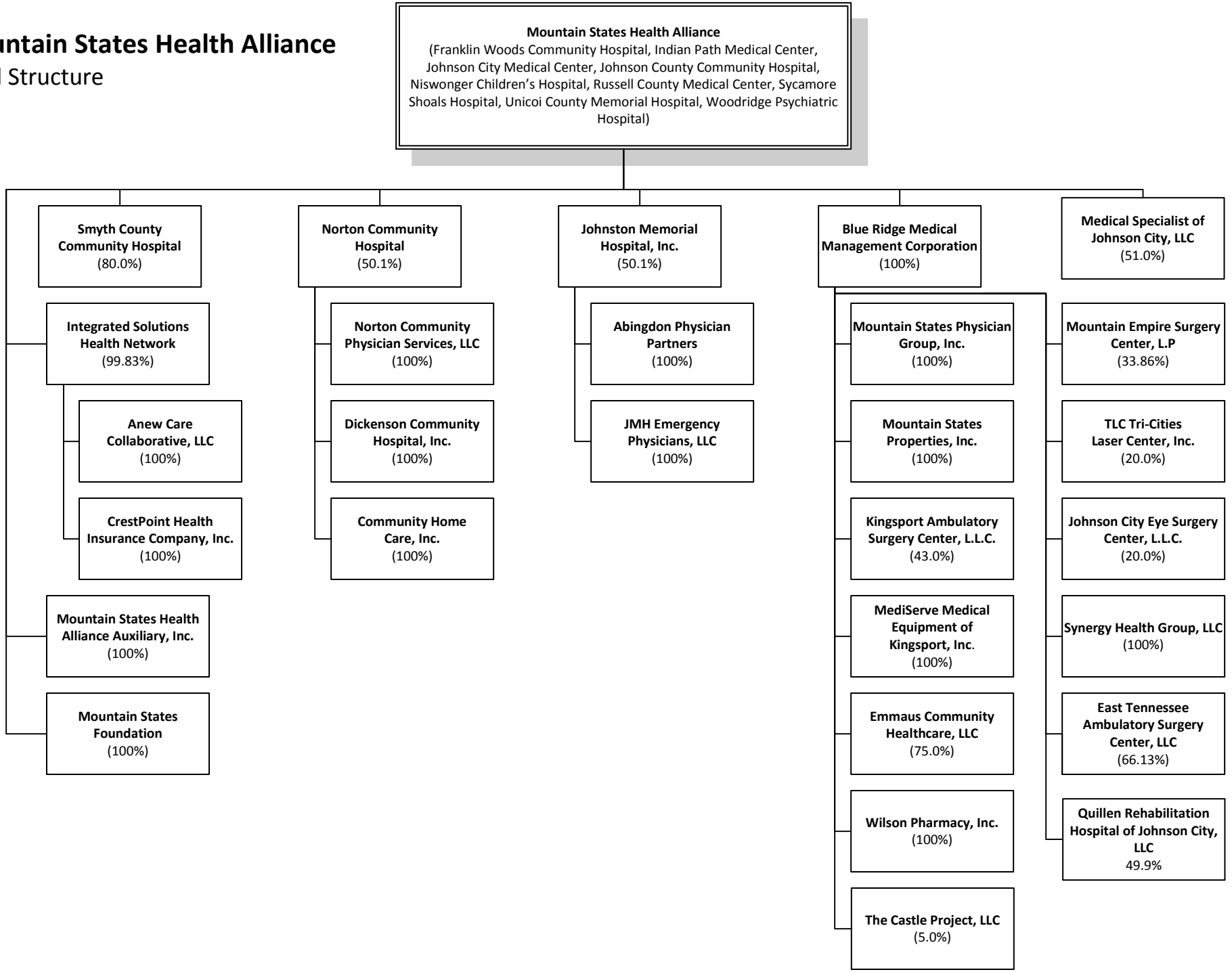


Exhibit B

See attached.

Wellmont Health System
Consolidated Organization Chart
June 1, 2015

WELLMONT HEALTH SYSTEM
(BRMC, HVMC, LPH
Hancock County, MountainView Regional, Corporate)
TIN:62-1636465

- **Wellmont Cardiology Services** (100%) TIN: 26-3557623
- **Wellmont Foundation, Inc.** (100%) TIN: 58-1594191
- **Wellmont/HealthSouth IRF, LLC** (Kingsport, Bristol) (100%) TIN: 20-5612001
- **Wellmont Madison House** (100%) TIN: 62-1308216
- **Wellmont Hawkins County Memorial Hospital, Inc.** (100%) TIN: 62-1816368
- **Wellmont Medical Associates** (100%) TIN: 27-0898372
- **Wellmont Health Management Services, Inc.** (100%) TIN: 62-1816370
- **Advanced Home Care** (5.76%) TIN: 58-1844651
- **Highlands Wellmont Health Network, Inc** (50%) TIN: 62-1551772
- **Renaissance Surgery** (33%) TIN: 20-0661765
- **Holston Valley Ambulatory Surgery Facility, LLC** (52%) TIN: 62-1816864
- **Sapling Grove Ambulatory Surgery Facility, LLC** (65%) TIN: 20-4450153
- **Wellmont Integrated Network, LLC** (100%) TIN: 45-5443060
- **Wellmont Health Management Services, LLC (WHMSLLC)** (100%) TIN: 62-1825259
- **Wellmont Medical Associates** (100%) TIN: 27-0898372
  - **Holston Valley Imaging Center** (99.9%) TIN: 20-2043285
- **Wellmont Sleep Services** (100%) TIN: 27-3777167
- **Wellmont Wexford House** (100%) TIN: 58-1859039
- **Wellmont Insurance Company SPC, LTD** (100%) TIN: 98-1195624
- **Wellmont Inc.** (100%) TIN: 62-1320035
  - **Wellmont Health Services Inc.** (100%) TIN: 62-1254373
    - **Professional Park Assoc., LLC** (12.72%) TIN: 62-1088798
    - **Bristol Surgery Center, LLC** (100%) TIN: 62-1225839
  - **Wellmont Physician Services, Inc.** (100%) TIN: 62-1567353
    - **WPS Providers, Inc.** (100%) TIN: 20-5564642
  - **Medical Mall Pharmacy** (100%) TIN: 62-1565006
  - **Medical Laundry of Tri-Cities** (100%) TIN: 62-1482226
  - **MCOT, Inc.** (100%) TIN: 62-1325938

Not-For-Profit Corporation (White)
For-Profit Corporation (Gray)

Approval Signature Date

Better Together

Wellmont Health System | Mountain States Health Alliance

Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report

PREPARED BY

Wellmont Health System & Mountain States Health Alliance

JANUARY 2016

About Our Systems

Wellmont Health System

Wellmont Health System operates six hospitals and numerous outpatient care sites, serving communities in Northeast Tennessee and Southwest Virginia. Wellmont's mission is to deliver superior healthcare with compassion, and we consistently rank among the nation's best for high-quality outcomes and processes of care.

Mountain States Health Alliance

Mountain States Health Alliance operates 13 hospitals and numerous outpatient care sites across a 29-county, four-state region. Mountain States is committed to its mission of bringing loving care to healthcare – and we passionately pursue healing of the mind, body and spirit to meet the needs of the individuals and communities in our region.

A Letter to the Community from Our Boards

In April 2015, we jointly announced our desire to create a new approach to healthcare in our region by bringing our two organizations together to form a new, integrated and locally governed health system. We have been working diligently since then, meeting with both internal and external stakeholders and engaging in a meticulous process to be sure that we're taking the right path as we prepare to seek approval to come together.

Most importantly, we've had countless conversations with individuals throughout the community who are eager to see the health status of our region improve, and they're excited about what the future holds for these counties we call home.

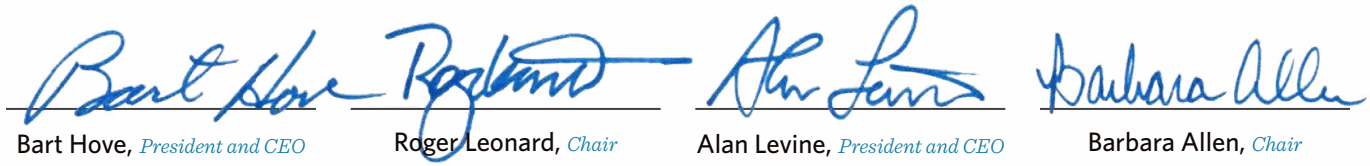
The document you now hold is an important step in the final approval process, and we could not be more excited about the possibilities it represents. This report and the applications that will follow it are part of what sets our vision apart from the traditional mergers that are so common in the healthcare industry today. An important difference is that we're involving you, the public, and making enforceable commitments to create an organization that has a measurable, positive impact on our region.

We've put a lot of careful thought into the commitments in this document, because we know that the decisions we make together today are going to impact our children, our grandchildren and even our great-grandchildren for many generations to come. That's another reason we believe that joining together is the right thing to do, because it allows us to keep governance of our local healthcare here at home. There will always be difficult decisions to make as we continue to navigate the changing and challenging world of health care, and we would rather those decisions be made by people who live here and have a personal stake in the outcomes. A great many of you have told us that this is your wish, as well.

We are your neighbors, and we hear your voice. We will be accountable not only to the states that will supervise us, but also to you, our friends and family. We take seriously our responsibility to act in the best interest of the communities we serve.

As you read through the commitments outlined in this report, we hope you will feel – and share – our enthusiasm for the great things we can do together to help our region thrive. Thank you for your continued support, and know that we value your thoughts and opinions. Our process is not complete without your input, so please let us know your thoughts on this report or any other subject by communicating with us at **www.BecomingBetterTogether.org**. We hope that the more we share about our vision, the more we will all agree that we truly are better together.

Sincerely,



Bart Hove, *President and CEO*
Wellmont Health System

Roger Leonard, *Chair*
Wellmont Health System
Board of Directors

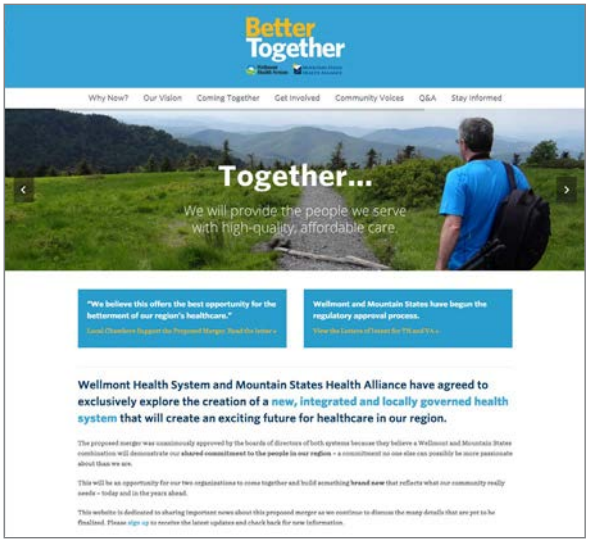
Alan Levine, *President and CEO*
Mountain States Health Alliance

Barbara Allen, *Chair*
Mountain States Health Alliance
Board of Directors

Purpose of the Report: Community Engagement and Feedback

This Pre-Submission Report provides the context for the proposed merger of Wellmont Health System and Mountain States Health Alliance to form a new health system (the "New Health System"), which was announced publicly in April 2015. Both systems have continuously sought to educate the public on the reasons for the merger, while also providing public opportunities for members of the community to provide input and ask questions. This transparency is not only the choice of the two organizations, it is also a requirement of the State of Tennessee and the Commonwealth of Virginia.

Wellmont and Mountain States have developed a formal process to collect community feedback. Immediately upon announcing the proposed merger, an informational website, **www.BecomingBetterTogether.org**, was created. This website provides information about the proposed merger, upcoming public events, frequently asked questions and a means to sign up for regular email updates and to submit questions. Frequently asked questions were answered on the website. The website link has been provided on collateral materials, and the public has been encouraged to ask questions. Questions may continue to be asked, and comments provided, by using the following link: **www.BecomingBetterTogether.org**



To date, Wellmont and Mountain States have participated in almost 40 scheduled community and media events that provided the public a chance to learn more and ask questions about the future of healthcare in the region. A record of the engagement to-date is included in this report as Attachment I. In addition, dozens of employee meetings and communications have been conducted throughout both organizations over the course of the last nine months, allowing substantive opportunities to ask questions and make comments.

Physician input has also been sought through medical staff and independent physician group meetings. In addition, both independent community physicians and physicians employed by each system have prominent leadership roles on the Integration Council and the Joint Board Task Force responsible for merger planning. Further venues for physician input are engrained in the original agreement between the two systems, which stipulates there will be a Clinical Council led by physicians, which reports through the Quality Committee of the new Board of Directors. It is the vision of the New Health System that physician input will be crucial to clinical and service-related issues after the completion of the merger. For more information on the Certificate of Public Advantage and Virginia Cooperative Agreement statutes and regulations, please see the following links:

TENNESSEE COPA STATUTE (TCA §68-11-1301 et seq.)
TENNESSEE COPA REGULATIONS
VIRGINIA COOPERATIVE AGREEMENT STATUTE
VIRGINIA COOPERATIVE AGREEMENT REGULATIONS

The Certificate of Public Advantage and Cooperative Agreement Process

This merger is contingent on the granting of a Certificate of Public Advantage by the State of Tennessee and a Cooperative Agreement with the Commonwealth of Virginia ("State Agreements"). Once granted, the State Agreements authorize Wellmont and Mountain States to merge and provide the framework for ensuring active supervision of the New Health System's compliance with these agreements and the mutually agreed enforceable commitments that benefit the community. Active supervision ensures that the benefits of the merger continue to outweigh any potential disadvantages and that the Tennessee and Virginia policies underlying the issuance of the State Agreements are fulfilled. The states require that the New Health System maintain a Plan of Separation so that if the benefits of the merger no longer outweigh the disadvantages, the plan can be operationally implemented without undue disruption to essential health services.

Each state separately evaluates the potential benefits of its State Agreement, considers whether one or more of the following benefits might result from the State Agreement, and assesses whether the benefits outweigh possible disadvantages. These benefits generally include:

- Enhancement of the quality of health and healthcare in the region
- Preservation of healthcare facilities in geographical proximity to the communities traditionally served by those facilities
- Gains in the cost-efficiency of services provided by the hospitals involved and prices paid by consumers
- Improvements in the utilization of hospital resources and equipment
- Avoidance of duplication of hospital resources

Background & Vision for the New Health System

Wellmont and Mountain States have served the health needs of residents in Northeast Tennessee and Southwest Virginia for decades. Both have invested in creating locally governed not-for-profit health systems to meet the unique needs of the region by providing a comprehensive array of services regardless of an individual's means of payment or ability to pay.

To move forward, the two systems have developed a comprehensive process to guide the design of the New Health System based on a shared vision, thoughtful analysis of current and future community health needs, significant feedback from the community, and oversight by both the State of Tennessee and Commonwealth of Virginia.

The vision of the proposed merger, which has been adopted by both Boards of Directors, sets forth that the New Health System will:

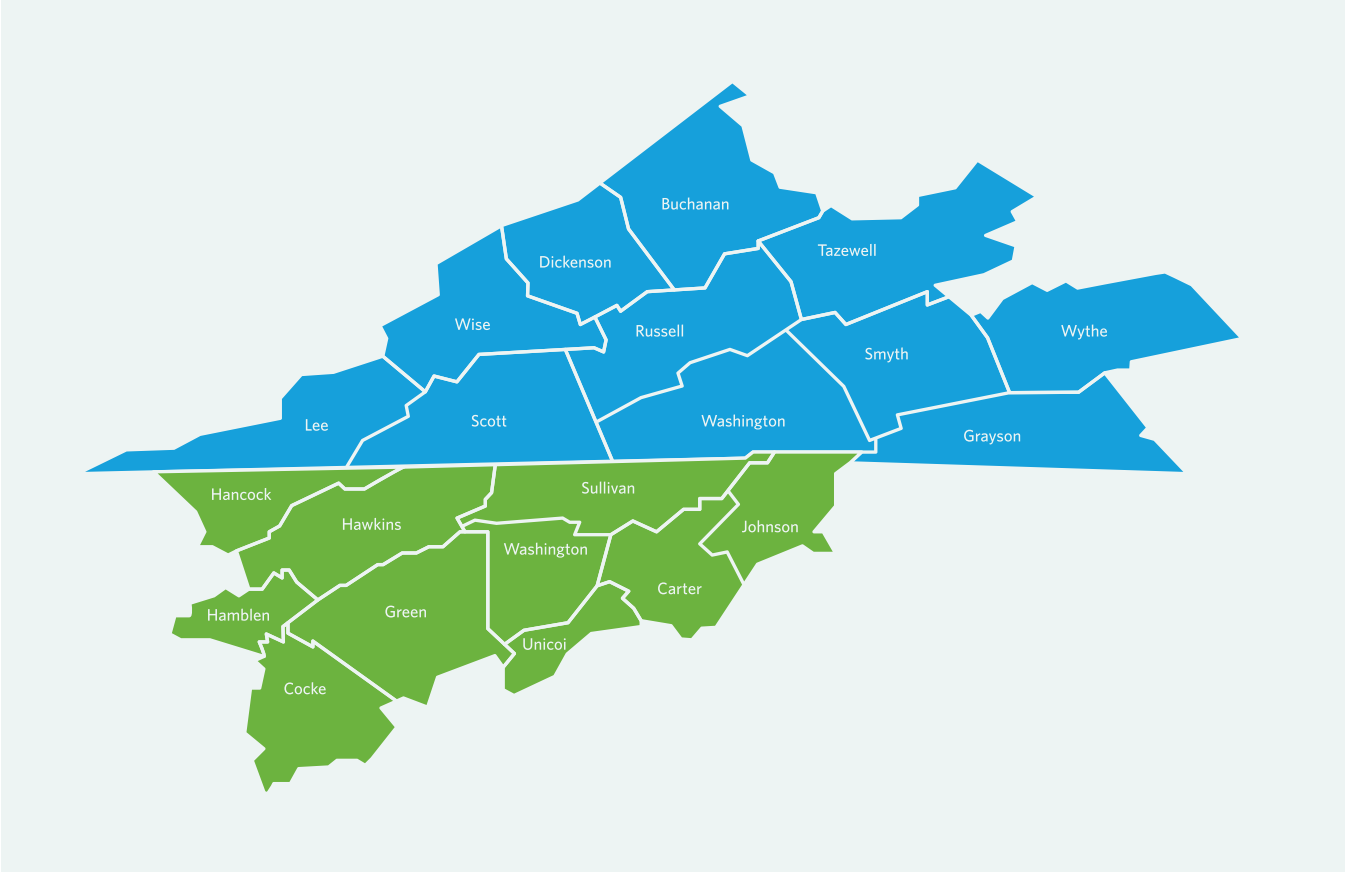
- Establish new unifying mission, vision, and values statements that honor our heritage and charter our future;
- Be one of the strongest health systems in the country, known for outstanding clinical outcomes and superior patient experiences;
- Be one of the best health system employers in the country 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 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; and
- Establish innovative philanthropic partnerships for healthcare advancement

The New Health System will have a new name and be governed by a new sixteen-member Board of Directors. This new Board initially includes: six (6) members appointed by Wellmont, six (6) members appointed by Mountain States, the Executive Chairman/President, the Chief Executive Officer, two (2) jointly appointed members not currently associated with the governance of either system, and the President of East Tennessee State University as an ex-officio nonvoting member. The New Health System will be managed by a senior executive team with representatives initially selected from each organization: Executive Chairman/President Alan Levine from Mountain States, Chief Executive Officer Bart Hove from Wellmont, Chief Operating Officer Marvin Eichorn from Mountain States and Chief Financial Officer Alice Pope from Wellmont.

Service Area and Facilities

The New Health System will primarily serve the following counties: Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee and Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise and Wythe in Virginia.

All Wellmont and Mountain States inpatient, outpatient, clinic, and support facilities will be included in the Tennessee COPA and Virginia Cooperative Agreement with the exception of those where the health systems do not own a controlling interest. For a more detailed listing, please see Attachment II.



Rationale for the Merger

For more than a year, the Boards of Directors of Wellmont and Mountain States each deliberated on how to best navigate a challenging environment for hospitals. This environment has resulted in the closure of more than 60 rural hospitals in the nation since 2010.[1] In addition, hundreds of local hospitals have been acquired by large multistate health systems or for-profit healthcare companies that lack deep-rooted understanding of local community health needs and have fiduciary obligations unaligned with the health of the local economy.

The challenges faced by our local systems contribute uniquely to the rationale for the proposed merger. There is a high concentration of services in our region with the third lowest Medicare Wage Index in the nation – leading to substantially lower reimbursement than peer hospitals in other states and in Tennessee for the same services. These challenges are intensified by a high proportion of Medicare, Medicaid, and uninsured patients. The two health systems have expensive, unnecessary duplicative healthcare resources that are allocated inefficiently; a merger would enable elimination of unnecessary duplication to capture large cost savings and realign resources to improve access and quality. In addition, there is projected downward pressure on reimbursement by government payers as costs for labor and supplies continue to grow. Collectively, we serve a region with one of the highest inpatient use rates; moreover these rates are projected to decline, while our fixed infrastructure costs remain. Further, there are increasing challenges with recruitment and retention of physicians as physicians retire and the newly trained physician supply does not support the demand. All of these challenges undermine the long-term sustainability of both systems and their ability to continue as independent, locally governed organizations.

Both systems are committed to maintaining the viability and vitality of regional assets in order to ensure access, manage the future costs of healthcare for local employers, and address the serious health issues affecting the communities in which we live and serve. Given the multitude of challenges faced by the two systems, combined with the consolidation that is occurring throughout the industry among hospitals, physician groups, insurance companies and even health information technology companies, it is clear that neither Wellmont Health System nor Mountain States Health Alliance will be able to remain independent moving forward. Given this reality, two options exist: merge locally to capture large merger-specific efficiencies and quality-enhancement opportunities through an integrated, locally governed regional health system or independently merge with large healthcare systems, located and controlled from outside our region – a step that would not come close to achieving the merger-specific benefits of a Wellmont-Mountain States integration. The proposed transaction, by far, positions the region to achieve the greatest level of public advantage and cost containment.

Outside hospital systems entering the region by acquisition most likely would not be subject to substantial antitrust scrutiny and, therefore, would have little or no reason to seek a COPA or Cooperative Agreement.

[1] University of North Carolina Sheps Center for Health Services Research, NC Rural Health Research Program. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

As such, they are free to acquire our local hospitals and take merger-related savings and jobs out of our communities without facing a requirement or local accountability to make the investments in community health that our region desperately needs. In fact, to the extent an outside system achieves any savings, most would inure to the benefit of the outside system and the dollars would most likely leave the region. Even if a system commits to spending a certain amount of capital locally, the capital is typically derived from the cash flow of the local hospital.

The boards of Wellmont and Mountain States believe the purchase of our local health systems by larger systems from outside our region is more likely to increase costs, reduce access, and negatively impact jobs.

We believe our proposed alternative is better. It is the only model that maintains local governance, provides a unique opportunity to sustain and integrate healthcare delivery for our residents into a high-quality and cost-effective system, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region, and invests those dollars in the improved health of our region while also preserving local jobs.

The process of obtaining the State Agreements, as outlined in state laws that follow a legal doctrine upheld by the Supreme Court of the United States, respects state autonomy in the regulation of its healthcare delivery system. The State Agreements permit hospitals that meet statutory requirements to consolidate in accordance with the state's policy, as long as the elements of the State Agreement are supervised by the states and provide clear public benefit. The standard acquisition by hospitals entering from "out of market" does not generally include these types of enforcement mechanisms to protect consumers or ensure enhanced community benefit.

We believe a locally governed merger by far provides the best opportunity for the local communities to retain control of the health delivery system. Our board members are local business owners and leaders, retirees and parents, all deeply affected by the decisions related to the future of the delivery system. This model provides tangible benefits for the community. When decisions are made, they are being made by people who must live with the consequence or benefit of the decision. This is the bedrock of the not-for-profit hospital model, which both systems believe is in the best interest of our region.

A major factor in the accumulation of nearly $1.5 billion of debt, and the redundant costs borne by the marketplace, has been the duplication of services and programming by Wellmont and Mountain States as separate systems. Combining the region's two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high-quality services moving forward. These efforts will produce savings that may be invested in higher-value activities in the region to help expand currently absent but necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need,

improve community health and diversify the economy into research. These new levels of development and job creation will not be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources. While consolidation will result in changes in the structure of the two organizations and displacement of some jobs, new development promises to create new job opportunities and advance the local economy. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community enhances health as well as economic well-being of the local economy, benefiting all. The benefit accrued to the community and resulting stimulus to the local economy will far outweigh any possible negative impact.

Through the State Agreements, the states of Tennessee and Virginia will be able to supervise the commitments the New Health System is making, which are described more fully herein. Further, the reinvested savings associated with the proposed merger provide compelling evidence that the resulting community benefit and public advantage will be substantial. These investments are described in more detail throughout the report. As examples, the New Health System will:

Invest not less than $75 million over ten years in population health improvements, committed through a regional ten-year plan

Invest not less than $140 million over ten years to expand mental health, addiction recovery, and substance abuse prevention programs; develop both healthcare- and community-based resources for children's health across the region; meet regional physician needs and address service gaps and preserve and expand rural services and access points

Invest not less than $85 million over ten years to develop and grow academic and research opportunities, support post-graduate healthcare training, and strengthen the pipeline and preparation of nurses and allied health professionals

Invest approximately $150 million over ten years to facilitate the regional exchange of health information among participating providers and to establish an electronic health record system within the New Health System that ensures a common platform and interoperability among its hospitals, physicians, and related services

Major Health Issues and Trends

According to the 2015 America's Health Rankings, Tennessee ranked 43rd and Virginia 21st in the U.S. for overall public health.[2] The county-level data in Table I, however, demonstrate that Northeast Tennessee and Southwest Virginia counties — the areas we serve — perform far worse than their state averages and are in fact among the unhealthiest counties in the United States. Based on County Health Rankings data published by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, the counties served by Wellmont and Mountain States rank among the worst in Virginia and Tennessee in several categories, notably in tobacco use, death due to drug poisoning and obesity.

Table I: Select Measures from County Health Rankings

Service Area Health Rankings By State, County or City	Overall State or County Health Rank	Percentage of Adults Reporting Fair or Poor Health	Percentage Of Adults That Are Obese	Percentage of Adults Who Are Currently Smokers	Percentage of Children In Poverty	Drug Poisoning Mortality Rate per 100,000 Population
Tennessee	**43rd**	**19%**	**32%**	**23%**	**27%**	**16**
Carter	48/95	23%	29%	31%	34%	20
Cocke	88/95	27%	31%	21%	41%	21
Greene	59/95	21%	32%	29%	30%	22
Hamblen	54/95	26%	30%	23%	29%	27
Hancock	93/95	29%	30%	40%	45%	42
Hawkins	64/95	26%	35%	26%	31%	26
Johnson	44/95	26%	31%	28%	38%	11
Sullivan	36/95	22%	33%	26%	28%	17
Unicoi	68/95	26%	30%	23%	29%	24
Washington	19/95	19%	31%	24%	24%	17
Virginia	**21st**	**14%**	**28%**	**18%**	**16%**	**9**
Buchanan	132/133	29%	29%	30%	33%	37
Dickenson	130/133	31%	29%	32%	28%	53
Grayson	74/133	20%	32%	22%	29%	Not reported
Lee	116/133	29%	29%	25%	39%	14
Russell	122/133	29%	35%	25%	26%	32
Scott	114/133	23%	34%	28%	27%	14
Smyth	123/133	29%	31%	22%	26%	15
Tazewell	133/133	29%	30%	21%	23%	37
Washington	82/133	19%	32%	24%	21%	13
Wise	129/133	24%	32%	33%	28%	38
Wythe	85/133	27%	30%	24%	22%	18

University of Wisconsin Population Health Institute. County Health Rankings 2015. Accessible at www.countyhealthrankings.org

[2] America's Health Rankings 2015 Annual Report. http://www.americashealthrankings.org/VA and http://www.americashealthrankings.org/TN

Commitment to Improve Community Health

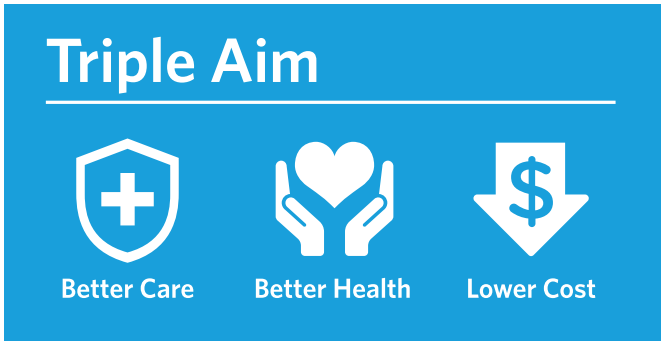
Wellmont and Mountain States are committed to creating a new health system designed to improve community health. To accomplish this, the New Health System will commit to pursuing health improvements aligned with goals contained within the current Tennessee State Health Plan, the Virginia Health Innovation Plan (including the Lieutenant Governor's Quality, Payment Reform, and HIT Roundtable and Virginia's Plan for Well Being) and with regional collaborative health improvement goals such as those set forth in Healthier Tennessee and the Blueprint for Healthy Appalachia. Additional local stakeholder input is being compiled by four Community Health Work Groups (mental health and addiction, healthy children and families, population health and healthy communities, and research and academics) organized by Wellmont and Mountain States.

All of these efforts recognize that income, education, family and community support, personal choices, genetics and the environment are key drivers of individual and community health and well-being. As the 2014 Tennessee Health Plan states, "We know that healthcare alone cannot make major improvements in population health. To make significant improvements, we need to understand what 'being healthy' and 'staying healthy' mean, and how to encourage our entire society to value health. In other words, we need to build a culture of health."

Yet each year, more of each employee paycheck, employer payroll and government budget is consumed by healthcare services, and less is invested in education, wage and job growth, public safety and other important investments. This is despite the fact the Institute of Medicine estimates that 30% of all healthcare service spending is wasted due to factors such as unnecessary and duplicative services, administrative burden, inefficient services, high prices, fraud and missed prevention opportunities.[3]

Hospitals and doctors have traditionally been paid to treat sick and injured patients. But Mountain States and Wellmont believe that redirecting savings identified from the merger into best-practice interventions aimed at the underlying causes of poor health in vulnerable populations will offer our best opportunity to improve the health of the overall population we serve. This requires a new approach that goes beyond the four walls of the health system and requires community collaboration and focus on a limited number of key problems and associated interventions. This necessitates both leadership and investment by the New Health System in partnership with many community stakeholders.

Fortunately, the region is primed for collaborative action to improve health in the form of a Regional (Northeast Tennessee-Southwest Virginia) Accountable Care Community (ACC). Successful ACC development requires multiple public and private stakeholders to commit to working collaboratively to advance the Triple Aim (better care, better health, and lower cost) in this region and to share the responsibility for the health of the community.



[3] IOM (Institute of Medicine). 2010. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press. At Preface xvi and p.50

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. Consistent with federal objectives to better engage communities, in the Commonwealth of Virginia, the creation of Accountable Care Communities (ACCs) is an important strategy of Virginia's State Innovation Model Design awarded by the federal government.

To develop a comprehensive plan for the region which the New Health System can provide financial and other support, we propose adopting a community-driven strategic planning process between the New Health System, the state, and local Department of Health and an organized community of stakeholders, which will prioritize program strategies to meet defined community health improvement goals. This process would be guided by the National Association of County and City Health Officials' (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) framework displayed to the right.

Analyzing the most current output of the Tennessee State Health Plan, the Virginia Health Innovation Plan, Healthier Tennessee and the Blueprint for Healthy Appalachia, and the four Community Workgroups, Mountain States and Wellmont have identified as a starting point four key strategic issues in which we believe the New Health System may make regional investments using redirected savings from the merger or whereby the merger itself aids in the achievement of these goals.

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.

The New Health System would commence the population health improvement process with the preparation of a comprehensive community health improvement plan, identifying 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 East Tennessee State University. The funding may be committed to the following initiatives, as well as others as determined based upon the 10-year action plan for the region.

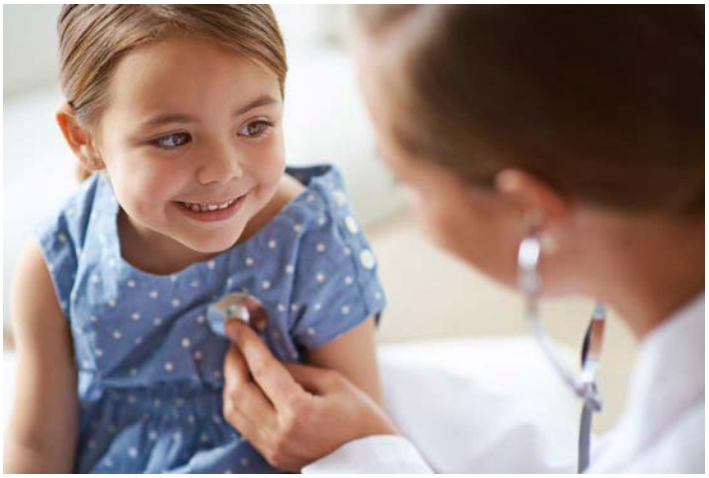
- **Ensure strong starts for children** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the 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 overprescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs.
- **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 New Health System will also provide financial support to develop and sustain an Accountable Care Community effort across state lines for our region that will help address these and other issues identified through the community health improvement plan.

A Community Health Work Group
held in the fall of 2015

Enhanced Healthcare Services

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.



Northeast Tennessee and Southwest Virginia are also victims of a flawed and antiquated federal funding program for Medicare, which depresses the reimbursement for our region relative to peer hospitals in other regions of the nation. The Medicare Wage Index adversely affects hospitals and doctors in our region, causing significant impediments to recruiting and retaining doctors, particularly specialists. For example, our hospitals are compensated at approximately 73 percent[4] of the average wage index for treating the same patient, with the same condition, for which a treating hospital in San Jose, California, would be compensated at 178 percent of the average wage index.[5] In the aggregate, this difference costs our region tens of millions of dollars annually in lower reimbursements, and has a substantial impact on physicians as well.

Providing these services is important and expensive. Why should rural families be required to expect less when it comes to access? Niswonger Children's Hospital, for example, continues to work to attract and support many subspecialties, but many families still travel significant distances to receive care. It is all too common that a child's illness forces families to split apart long-term or creates job loss as one parent must work while the other travels as a full-time caregiver. We don't believe these disparities should prevail and are prepared to make investments to ensure the most vulnerable have improved access.

Families and individuals suffering from the prescription drug addiction epidemic and other substance abuse disorders face even more difficult challenges. Funding has not kept up with needs and our local systems are overwhelmed. Families again face the difficult choice of splitting apart as loved ones must travel long distances to receive services, or even worse, can't find services at all or face long waits.

The proposed merger will produce savings which will be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise couldn't be supported in a region of our size, geography and population density. In addition, the proposed merger will provide a unique opportunity for the New

[4] This figure represents the average across Johnson City, TN and the Kingsport-Bristol-Bristol, TN-VA MSAs.

[5] CMS Fiscal Year 2015 Wage Index Table, available here: https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/wageindex.html

Health System to work with academic institutions in the region to increase training and recruitment of physicians and allied health professionals. Developing our own workforce connected with the region and likely to stay here long-term provides a strong supplement to recruitment efforts for other top-tier doctors, nurses and allied health professionals from other parts of the country.

The New Health System commits to spending at least $140 million over ten years pursuing specialty services, outlined as follows, which otherwise could not be sustainable in the region without the financial support. Partnerships with academic institutions will enable research-based and academic approaches to the provision of these services.

- Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
- Develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements.
- Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.
- 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.
- 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. We expect the combined system to facilitate this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding.

Expanding Access and Choice

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.

In the U.S., rural hospitals and healthcare providers are at increasing risk. According to the University of North Carolina Sheps Center, 61 rural hospitals have closed since 2010, including six in Tennessee and one in Virginia.[6] Wellmont and Mountain States each make substantial investments in order to maintain access to health care services in their rural communities.

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. This does not include significant additional capital investments.

Mountain States Rural Hospitals:

- Smyth County Community Hospital
- Russell County Medical Center
- Unicoi County Memorial Hospital
- Johnson County Community Hospital
- Dickenson Community Hospital
- Norton Community Hospital
- Johnston Memorial Hospital

Wellmont Rural Hospitals:

- Hawkins County Memorial Hospital
- Hancock County Hospital
- Lonesome Pine Hospital
- Mountain View Regional Medical Center

For the reasons discussed above, it will be increasingly difficult to continue sustaining these facilities over the long-term without the savings the proposed merger would create. Protecting and increasing patient choice is important to Mountain States and Wellmont. By integrating our two systems, we will help ensure that our communities continue to have access to the care they need close to home and that care options are expanded rather than reduced. Currently, more than one-quarter of inpatient admissions in the region occur at hospitals other than those owned by the two systems. Most outpatient medical services are actually delivered outside the two systems by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, long-term care services, skilled nursing, physical therapy, occupational therapy, pharmacy, counseling, and surgery centers. Wellmont and Mountain States are required to ensure patient choice when selecting these services and will continue these policies as a merged organization.

[6] University of North Carolina Sheps Center for Health Services Research, NC Rural Health Research Program. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

After the merger, patient choice of hospitals will increase. Currently, some patients are limited to either Wellmont or Mountain States hospitals because of constraints in insurance networks. Similarly, many doctors are limited to practice in certain hospitals by contract. In each of these examples, patient choice is limited in the current environment. As another example, in some areas of the region, patients are often referred to hospitals farther away than more local hospitals, because the closer hospitals are part of the competing system. This inconvenience exists because of the continuum of care and physician relationships that arise between the facilities and because of transfer patterns from community hospitals to tertiary centers within the same system. Through the proposed merger, a more comprehensive and fully integrated regional network will improve patient choice and convenience, as these barriers would be removed.

Both Wellmont and Mountain States continue to value a robust and successful independent physician community. The New Health System intends to collaborate with the independent physician community where possible to build an array of service offerings which will also be accessible throughout the region.

The New Health System will invest in the development of expanded services while preserving services currently at risk through the following commitments.

- All hospitals in operation at the effective date of the merger will remain operational as clinical and healthcare institutions for at least five (5) years. After this time, the New Health System will continue to provide access to healthcare 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 healthcare and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.
- 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.
- 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.
- Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.
- Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.
- The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.

Improving Healthcare Value: Managing Quality, Cost and Service

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 healthcare cost growth for patients, employers and insurers. Currently, 126 patients for every 1,000 people in Tennessee are admitted to the hospital annually, compared to a national average of 106 admissions/1,000 population.[7] We believe a regionally integrated health system, with a comprehensive regional health information exchange, will help reduce unnecessary utilization.

The proposed merger will also result in a common platform for electronic medical records among the merging systems' combined nineteen hospitals, many employed physicians and related services and will facilitate a community health information exchange between participating community providers in the region. This will help ensure that providers have the information they need to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. Patient information will be more portable, removing barriers to patient choice and improving patient access to their own health information. A more integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services, resulting in a better patient experience and more effective and efficient care.

The merger will also allow for better clinical integration as the combined system reduces unnecessary variation in standards of care created by the simple fact that the two systems operate separately in silos and from the independent physician community. Given the significant pressure on health systems and independent physicians to deliver higher-quality care and service from Medicare and commercial payers, a unified merged system working with the independent physician community will be able to more rapidly adopt and disseminate best practices.

[7] Kaiser Family Foundation, Hospital Admissions per 1,000 Population by Ownership Type. (2013) http://kff.org/other/state-indicator/admissions-by-ownership/

The New Health System will reduce cost through improved efficiency and avoidance of waste and duplication, as well as reduce the pace of healthcare cost growth for patients, employers and insurers through the following commitments:

- For all Principal Payers,* the New Health System will reduce existing commercial-contracted fixed-rate increases by 50% for the first full contract year following the first contract year after the formation of the New Health System.
- 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%.
- The United States Government 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. For all non government 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.
- 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.
- Adopt a common clinical information technology platform as soon as reasonably practical after the formation of the New Health System.
- Participate meaningfully in a health information exchange open to community providers.
- Establish annual priorities related to quality improvement and publicly report these quality measures in an easy-to-understand manner for use by the patients, employers and insurers.
- 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 certain limitations). The New Health System would agree to resolve through mediation any disputes in health plan contracting.
- Not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.
- Not engage in "most-favored-nation" pricing with any health plans.

* "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue

Investment in Health Research and Graduate Medical Education

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 region is fortunate that Quillen College of Medicine, Lincoln Memorial University DeBusk College of Osteopathic Medicine, the Virginia College of Osteopathic Medicine, and Virginia Tech excel at educating physicians who choose to practice primary care and in rural areas.

Yet, due to financial constraints, Wellmont and Mountain States have reduced the number of residency slots in their respective systems to train these graduate physicians. Multiple studies have shown that physicians tend to locate their practice close to where they train in residency. And increasingly important to the primary care workforce are nurse practitioners and physicians assistants trained at schools such as Emory & Henry, Milligan College and the ETSU School of Nursing. Unlike physician programs, historically little funding has been available for these programs from the federal and state governments.

By investing funds generated through merger efficiencies, the New Health System will increase residency and training slots, create new specialty fellowship training opportunities, build research infrastructure, and add faculty - 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.

The New Health System will work with its academic partners 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 as outlined below – all critical to sustaining an active and competitive training program.

- With academic partners in Tennessee and Virginia, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.
- Work closely with East Tennessee State University (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.

Attracting and Retaining a Strong Workforce

Our workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for our team members. Thus, competitiveness of our pay and benefits is critical to our success. We believe certain federal policies, which have adversely affected the region's wage index, have also contributed to relocation out of market as being a primary cause of turnover. As such, the New Health System's biggest competitor for labor will continue to be regional systems located out of the immediate market. Additionally, with the Veteran's Administration hospital and services located in-region, as well as the multitude of outpatient services offered by local competition, there will be incentives for the new system to remain locally competitive for talent.

In addition, staffing is generally driven by volume. As such, if the demand for nurses, technicians and other clinical staff diminishes in the future, it will not be due to the merger but rather to the ongoing transformation of the healthcare industry. As outlined in this document, new programs to improve community health will be added and funded, all of which will need exceptional talent.

In addition to being competitive for labor, and mitigating the local impact on jobs, we are also committed to our existing workforce – our neighbors and friends who are the strength of our two organizations. We recognize that our workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for our team members. Thus, competiveness of pay and benefits is critical to the New Health System's success.

Therefore, when the New Health System is formed:

- 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 our vision to be 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.

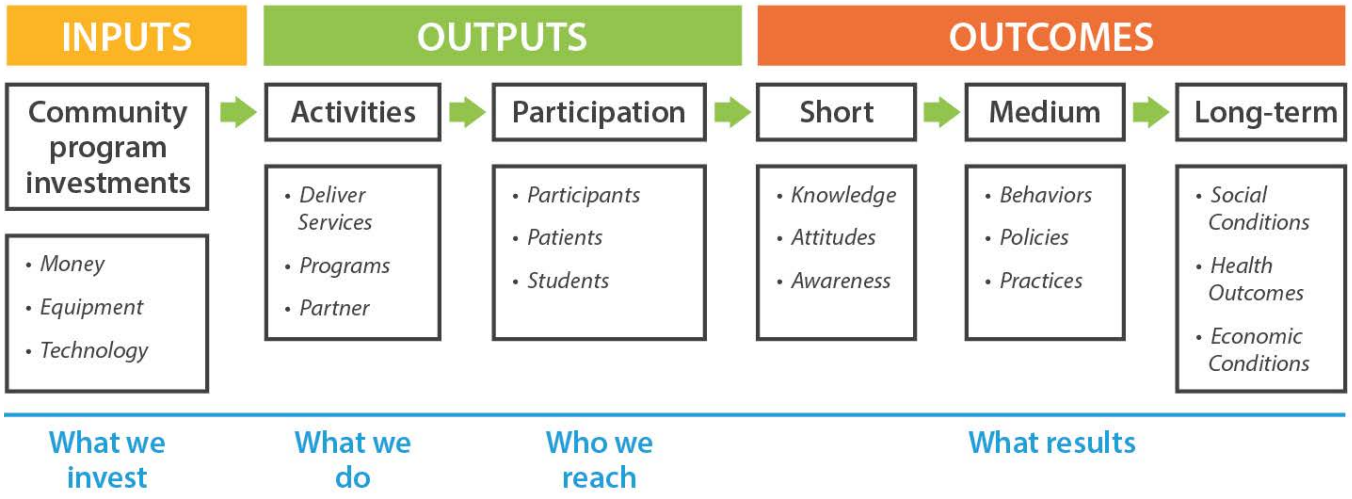
Measuring Progress

It is ultimately the goal of the New Health System to achieve the Institute of Health Improvement's Triple Aim, commonly considered the national standard for evaluation of healthcare effectiveness. As part of our applications for a COPA in Tennessee and Cooperative Agreement in Virginia, we propose that ongoing evaluation of the public advantage resulting from the merger be based on the New Health System's pursuit of the Triple Aim objectives to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of healthcare in the region.

Before the Tennessee COPA and Virginia Cooperative Agreement is granted, each State and the New Health System should agree on key health concerns as well as a limited number of long-term health outcomes for tracking within four strategic area of focus: strong starts for children, living well in the community, promoting a drug-free community and decreasing avoidable inpatient and ER use by high need-high cost uninsured individuals. As an important component of the evaluation of each application, each State will separately establish advisory groups made up of stakeholders from the area to recommend measures for consideration to objectively track the ongoing public advantage of the Tennessee COPA and Virginia Cooperative Agreement. Agreement on these specific tracking measures should serve as the guide for long-term programmatic investment by the New Health System to improve community health.

Monitoring and evaluating the continued Public Advantage produced under the Tennessee COPA and the Virginia Cooperative Agreement are essential. We are committed to close coordination with the states to establish clear processes for both monitoring and evaluation. Because evaluation of commitments regarding population health are more complex and involve many factors, both shorter-term and longer-term, we propose to use the Kellogg Foundation's Logic Model to inform the evaluation of these commitments.

Kellogg Foundation Logic Model for Evaluation



Under this model, effective measures by which we can evaluate progress towards long-term outcomes would reflect incremental investment in programs (inputs), measurements of activities and participation related to these programs (outputs), and outcomes, both short-term and medium-term. The short-term outcomes could include measurable changes in learning, such as awareness, knowledge, attitudes, skills, opinions, aspirations, and motivations. The medium-term outcomes could include measurable changes to actions such as behaviors, practices, decision making, polices, and social norms.

We believe close collaboration with the community, investment by the New Health System, and commitment to continuous and ongoing evaluation and improvement will result in positive short- and long-term outcomes that are only possible through the State Agreements.

Conclusion: Becoming Better Together

Our region has a once in a lifetime opportunity to create a long-lasting legacy of improved health by pursuing a merger between Wellmont and Mountain States. With the approvals of the states under the State Agreements, savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially through new services and capabilities, improved choice and access, managed costs and investment in both the region's economic development and its most challenging health problems.

Once the annually recurring merger related synergies have been fully realized, this merger will produce a level of annual spending to improve the health of the region equivalent to at least the spending capability of a new three-quarters of a billion dollar foundation. All of this investment will be in Northeast Tennessee and Southwest Virginia, and it will focus on improving the health, well-being, and economy of the communities we serve. Importantly, we can do all of this while maintaining local control of our healthcare system and improving the quality and cost of care.

Again, you may submit questions or make comments regarding this Pre-Submission Report using the link below:

www.BecomingBetterTogether.org

Better Together

Wellmont Health System

Mountain States Health Alliance

Appendix

ATTACHMENT I: COMMUNITY EVENTS, CORRESPONDENCE AND MEDIA INTERVIEWS

COMMUNITY EVENTS & PRESENTATIONS	
April 2, 2015	Proposed merger announcement public event
April 24, 2015	Kingsport Chamber breakfast
May 1, 2015	Bristol Tennessee/Virginia Chamber breakfast
May 6, 2015	Washington County Virginia Rotary
May 19, 2015	Johnson City Chamber Board
June 8, 2015	Kingsport Chamber Board
June 10, 2015	Southwest Virginia Health Authority
June 24, 2015	Bristol Tennessee/Virginia Chamber Board
July 7, 2015	Bristol Tennessee/Virginia Noon Rotary
July 23, 2015	Washington County Virginia Chamber Board
August 13, 2015	Elizabethton Community Round Table
August 20, 2015	Mental Health & Addiction Steering Committee
August 20, 2015	Abingdon Community Round Table
August 24, 2015	Population Health & Healthy Communities Steering Committee
August 28, 2015	Kingsport Chamber Breakfast
September 3, 2015	Virginia Department of Health Public Hearing
September 8, 2015	Healthy Children & Families Steering Committee
September 9, 2015	Mountain States Foundation Women's Luncheon
September 15, 2015	Marion Community Round Table
September 16, 2015	Johnson City Press Public Forum
September 17, 2015	Mental Health & Addiction Steering Committee
September 19, 2015	Sorensen Institute presentation
September 19, 2015	Lead Virginia
September 24, 2015	Research & Academics Steering Committee
September 24, 2015	Erwin Community Round Table
September 28, 2015	Population Health & Healthy Communities Steering Committee
September 29, 2015	Lebanon, Virginia, Community Round Table
September 30, 2015	Johnson City Rotary
October 1, 2015	Kingsport Community Round Table
October 6, 2015	Duffield Community Round Table
October 13, 2015	Healthy Children & Families Steering Committee
October 15, 2015	Bristol Community Round Table
October 16, 2015	Regional Health Care Symposium
October 20, 2015	Wise Community Round Table
October 21, 2015	Mental Health & Addiction Steering Committee

October 22, 2015	Johnson City Community Round Table
October 22, 2015	United Way of Southwest Virginia Summit
October 26, 2015	Population Health & Healthy Communities Steering Committee
October 28, 2015	Research & Academics Steering Committee
November 10, 2015	Healthy Children & Families Steering Committee
November 12, 2015	Johnson City Rotary
November 16, 2015	All Work Groups Meeting – Accountable Care Communities
November 16, 2015	Population Health Steering Committee
November 19, 2015	Mental Health & Addiction Steering Committee
December 2, 2015	Research & Academics Steering Committee
December 8, 2015	Healthy Children & Families Steering Committee
December 18, 2015	Mental Health & Addiction Steering Committee
December 18, 2015	All Work Groups Meeting – Impact of Opioids in Appalachia
See **www.BecomingBetterTogether.org** for additional upcoming events.	

COMMUNITY CORRESPONDENCE & ANNOUNCEMENTS	
April 2, 2015	Proposed merger announcement news release
April 2, 2015	Launch of www.BecomingBetterTogether.org
April 7, 2015	Integration Council announcement news release
April 16, 2015	Better Together newsletter
May 6, 2015	Better Together newsletter
May 7, 2015	Joint Board Task Force announcement news release
June 2, 2015	Better Together newsletter
June 10, 2015	Better Together newsletter
June 10, 2015	Community Health Work Groups announcement news release
August 5, 2015	Better Together newsletter
August 5, 2015	Community Health Work Groups chairs & meeting dates announcement news release
August 24, 2015	Better Together newsletter
September 16, 2015	Letter of Intent announcement news release
September 16, 2015	Better Together newsletter

MEDIA INTERVIEWS	
April 2, 2015	Proposed merger announcement interviews
April 22, 2015	Kingsport Times-News editorial board
April 22, 2015	WJHL editorial board
April 23, 2015	WCYB editorial board
April 23, 2015	Johnson City Press editorial board
May 7, 2015	WKPT editorial board
June 8, 2015	HealthLeaders Media
June 10, 2015	Community Health Work Groups announcement & interviews
June 11, 2015	Modern Healthcare interview
August 24, 2015	WJHL interview

September 16, 2015	Letter of Intent announcement interviews
September 16, 2015	Johnson City Press Forum and follow-up interviews
October 6, 2015	Interview with WCYB
October 12, 2015	Interview with the Johnson City Press
October 16, 2015	Interview with the Bristol Herald Courier
October 19, 2015	Interview with The Business Journal
November 11, 2015	Interviews with The Tennessean and WJHL
November 12, 2015	Interview with The Tennessean
November 13, 2015	Statement provided to the Johnson City Press, Roanoke Times and WKPT
November 16, 2015	Statement provided to WJHL
November 20, 2015	Statement provided to WJHL
December 1, 2015	Statement provided to WCYB
December 9, 2015	Statement provided to the Johnson City Press
December 15, 2015	Statement provided to The Business Journal and the Johnson City News & Neighbor
December 17, 2015	Statement provided to WJHL
December 23, 2015	Statement provided to The Post
December 28, 2015	Statement provided to the Johnson City Press
December 30, 2015	Statement provided to WXBQ and the Kingsport Times-News

Appendix

ATTACHMENT II: INCLUDED FACILITIES AND SERVICES

Wellmont Hospitals Wellmont's hospital operations consist of two tertiary referral medical centers: Holston Valley Medical Center in Kingsport, Tennessee, and Bristol Regional Medical Center in Bristol, Tennessee, and four wholly owned community hospitals: (1) Mountain View Regional Medical Center in Norton, Virginia, (2) Lonesome Pine Hospital in Big Stone Gap, Virginia, (3) Hawkins County Memorial Hospital in Rogersville, Tennessee, and (4) Hancock County Hospital, a critical access hospital, in Sneedville, Tennessee.	
Holston Valley Medical Center (Kingsport, TN)	Holston Valley Medical Center has been serving the Kingsport community for 80 years since opening in 1935. The 505-bed facility is staffed by more than 450 board- certified or board-eligible physicians and over 1,700 employees. Holston Valley Medical Center is a regional tertiary referral center offering a comprehensive array of inpatient and outpatient services, including advanced services and trauma services. The hospital serves as a teaching facility in partnership with schools such as East Tennessee State University and Lincoln Memorial University. It is an affiliate of Children's Miracle Network Hospitals.
Bristol Regional Medical Center (Bristol, TN)	Bristol Regional Medical Center, founded in 1925, operates in a state-of-the-art facility that opened in 1994. The 348-bed facility is staffed by more than 336 board-certified or board-eligible physicians and over 1,600 employees. Bristol Regional Medical Center is a regional tertiary referral center offering a comprehensive array of inpatient and outpatient services, including advanced services and trauma services. The hospital serves as a teaching facility in partnership with schools such as East Tennessee State University and Lincoln Memorial University. It is an affiliate of Children's Miracle Network Hospitals.

Wellmont Community Division Hospitals Wellmont community division hospitals include Lonesome Pine Hospital, Mountain View Regional Medical Center, Hawkins County Memorial Hospital, and Hancock County Hospital.	
Lonesome Pine Hospital (Big Stone Gap, VA)	A 60-licensed bed facility that has served the community since 1973. Lonesome Pine is a community hospital offering a full array of services, including emergency services and a variety of inpatient and outpatient services. The hospital serves as a teaching facility in partnership with schools such as Lincoln Memorial University. The Southwest Virginia Cancer Center, serving medical and radiation oncology patients, is part of Lonesome Pine Hospital operations. Lonesome Pine is staffed with 167 physicians, of whom 80% are board certified, and nearly 400 employees.
Mountain View Regional Medical Center (Norton, VA)	Mountain View is a 118-licensed bed full-service hospital and offers a full array of services, including emergency services and a variety of inpatient and outpatient services.. Mountain View joined Wellmont in 2007 and it is operated as a facility of Lonesome Pine Hospital under one Medicare provider number. Mountain View Regional Medical Center houses the system's only hospital-based long-term care unit. For financial reporting purposes, Mountain View is consolidated with Lonesome Pine.

Mountain View Regional Medical Center (Norton, VA)	Mountain View is a 118-licensed bed full-service hospital and offers a full array of services, including emergency services and a variety of inpatient and outpatient services.. Mountain View joined Wellmont in 2007 and it is operated as a facility of Lonesome Pine Hospital under one Medicare provider number. Mountain View Regional Medical Center houses the system's only hospital-based long-term care unit. The hospital serves as a teaching facility in partnership with schools such as Lincoln Memorial University. For financial reporting purposes, Mountain View is consolidated with Lonesome Pine. It is an affiliate of Children's Miracle Network Hospitals.
Hawkins County Memorial Hospital (Rogersville, TN)	Established in 1961, the 50- bed hospital provides care in a rural setting. Hawkins County is staffed by more than 121 board-certified or board-eligible physicians and nearly 150 employees. Hawkins County Memorial is a community hospital offering a full array of services, including emergency services and a variety of inpatient and outpatient services. The hospital is a teaching facility in partnership with East Tennessee State University.
Hancock County Hospital (Sneedville, TN)	This 10-bed facility has been designated by the state as a critical-access hospital that provides care to a medically underserved region. Hancock County was built through a partnership between the system and the Hancock County Commission. Hancock County offers emergency services and a variety of inpatient and outpatient services. Additionally, air and ground medical transportation to a larger tertiary-care facility is available should a patient require further specialization. Hancock County is staffed with 40 physicians, of whom 68% are board certified. It is an affiliate of Children's Miracle Network Hospitals.

Wellmont Corporate Entities: Ambulatory and Post-Acute Services Wellmont has been proactive in developing its capabilities across the care continuum through a variety of platforms, including medical groups, assisted living and skilled nursing care facilities, ambulatory surgery centers, urgent care facilities and other ancillary service offerings.	
Wellmont Medical Associates	A multispecialty practice group, Wellmont Medical Associates includes 135 physicians and 67 mid-levels and nurse practitioners, who deliver care in a number of fields.
Wellmont Cardiology Services	The Wellmont CVA Heart Institute offers an integrated approach with leading cardiovascular physicians and cutting-edge cardiovascular technologies and treatments. The institute includes 45 cardiovascular physicians, 23 physician assistants and nurse practitioners, and 575 cardiovascular service line employees.
Wellmont Madison House	The region's only healthcare-affiliated assisted living residence, adult day care center and short-term overnight care program. The facility provides accommodations for 29 residents with staff supervision and access to 24-hour personal assistance. Services available to assisted living residents are also available to those in the short-term overnight care program.
Wexford House (Kingsport, TN)	A 174-bed skilled and long-term care facility, Wexford House provides comprehensive skilled and rehabilitative nursing care, including: physical therapy, speech therapy, and occupational therapy; residential custodial care; respite and hospice care.

Wellmont/Health South IRF, LLC (Bristol, VA)	Joint venture between Wellmont and HealthSouth Corp., a national healthcare provider specializing in rehabilitation, to operate the Rehabilitation Hospital of Southwest Virginia in Bristol, Virginia. (25% Ownership)
Bristol Surgery Center (Bristol, TN)	Ambulatory surgery center located in Bristol, Tennessee.
Sapling Grove Ambulatory Surgery Center (Bristol, TN)	Ambulatory surgery center located in Bristol, Tennessee. The remaining ownership interest is held by various physicians. (65% Ownership)
Holston Valley Ambulatory Surgery Center (Kingsport, TN)	Ambulatory surgery center located in Kingsport, Tennessee. The remaining ownership interest is held by various physicians. (52% Ownership)
Marsh Regional Blood Center	Marsh Regional Blood Center is a wholly owned subsidiary of Wellmont that provides whole blood and other blood products to 16 hospitals and multiple cancer facilities in Northeast Tennessee and Southwest Virginia. Marsh Regional operates donor centers in Kingsport, Tennessee, and Bristol, Tennessee, and conducts mobile blood drives throughout the region.

Wellmont Corporate Entities: Integrated Support In addition to Wellmont entities that involve direct patient care and service, Wellmont has also developed strong financial and operational support capabilities through the creation of a captive insurance company, a physician hospital organization, and a philanthropic foundation, which all support the system.	
Wellmont Insurance Company SPC, LTD	Cayman captive insurance company which has been established for the purpose of insuring Wellmont's self-insured initial layer of professional liability coverage.
Highlands Wellmont Health Network	A physician hospital organization jointly owned by Wellmont Health System and Highlands Physicians, Inc. The organization includes around 1,000 physicians across the region along with Wellmont's inpatient and outpatient resources, providing a regional option for direct employer contracts and a platform for focused networks. (50% Ownership)
Wellmont Foundation, Inc.	A Tennessee nonprofit corporation and a 501(c)(3) organization, supports the mission, vision and values of Wellmont through the use of community involvement and philanthropic support. As the fundraising arm of Wellmont, Wellmont Foundation serves all of its hospitals and service lines throughout the region.

Mountain States Health Alliance Hospitals All Mountain States wholly owned hospitals operate under the tax identification number of the Mountain States Health Alliance Corporation. The wholly-owned Mountain States acute care hospitals are described below.	
Johnson City Medical Center (JCMC) (Johnson City, TN)	JCMC is a 445- bed regional tertiary referral center which also serves as a teaching hospital affiliated with East Tennessee State University. Founded in 1911, JCMC has transformed to provide a comprehensive array of inpatient and outpatient services, including advanced services and trauma services. Also located at JCMC are 34 skilled nursing beds, separately licensed as Franklin Transitional Care.
Niswonger Children's Hospital (Johnson City, TN)	Niswonger Children's Hospital is the region's only children's hospital. The 69-bed facility is staffed by pediatric experts to serve more than 200,000 children in a four-state, 29-county region. Niswonger provides a comprehensive array of inpatient and outpatient services for children. Niswonger houses one of only seven St. Jude Affiliate Clinics across the country.
Woodridge Psychiatric Hospital (Johnson City, TN)	Woodridge Psychiatric Hospital is an 84-bed inpatient provider of mental health and chemical dependency services for adults, adolescents, and children ages six and older. Woodridge is a psychiatrist-led facility that includes a team of mental health therapists, discharge planners, expressive therapists, and psychiatric nurses to assist the patient with finding the most beneficial level of treatment.
Indian Path Medical Center (Kingsport, TN)	Indian Path Medical Center (IPMC) is a 239-bed community hospital with roots dating back 40 years. Indian Path provides a full array of services, including emergency services and a variety of inpatient and outpatient services.
Sycamore Shoals Hospital (Elizabethton, TN)	Sycamore Shoals Hospital is a 121-bed acute care facility serving the residents of Carter and Johnson Counties. Sycamore Shoals offers a full array of services, including emergency services and a variety of inpatient and outpatient services. In addition, wellness services are provided through the Franklin Health and Fitness Center, located on the campus of Sycamore Shoals.
Franklin Woods Community Hospital (Johnson City, TN)	Franklin Woods Community Hospital is an 80-bed, LEED-certified* "green" facility. Opened in 2010, Franklin Woods provides a full array of services, including emergency medicine and a variety of inpatient and outpatient services. *Leadership in Energy and Environmental Design
Unicoi County Memorial Hospital (Erwin, TN)	Unicoi County Memorial Hospital, is a 48-bed acute care facility with an adjacent 46-bed skilled nursing facility. The hospital was founded in 1953 in Erwin, TN, and serves the residents of Unicoi County and the surrounding areas with a full array of services, including emergency services and a variety of inpatient and outpatient services.
Russell County Medical Center (Lebanon, VA)	Russell County Medical Center is a 78-bed, acute care and behavioral health hospital. The hospital serves the residents of Russell County, VA, and provides behavioral health services, emergency services, and a variety of inpatient and outpatient services.

Johnson County Community Hospital (Mountain City, TN)	Johnson County Community Hospital is a two-bed critical access hospital opened in 1998 by Mountain States Health Alliance, offering emergency services and a variety of inpatient and outpatient services to the residents of Johnson County.

Mountain States' Joint Venture Facilities Mountain States' integrated healthcare delivery system also includes joint ventured facilities. The following summaries describe the joint venture entities.	
James H. and Cecile Quillen Rehabilitation Hospital (Johnson City, TN)	Quillen Rehabilitation Hospital houses 26 inpatient rehabilitation beds. The hospital is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and also provides a CARF-accredited stroke program. QRH offers pediatric and adolescent therapy for a wide range of diagnoses, such as stroke, brain injury, amputation, spinal cord injury, orthopedic injury, rheumatologic impairments, neurological and neuromuscular problems and major multiple trauma. The Mountain States partnership with HealthSouth consists of a stand-alone rehabilitation hospital joint venture of at least 36 rehab beds, with Mountain States maintaining a minority interest, and 50/50 board presence. The partnership with Signature HealthCARE will result in a skilled nursing facility with 47 beds and an assisted living facility with 60 beds.
Smyth County Community Hospital (Marion, VA)	Smyth County Community Hospital is a 44-bed, acute care facility located in Marion, VA. Smyth County's services also include a 109-bed skilled nursing care facility, branded as Francis Marion Manor Health & Rehabilitation. The hospital has served the residents of Smyth County, VA, for more than 45 years through a full array of services, including emergency services and a variety of inpatient and outpatient services. Smyth County Community Hospital also owns 100% of Southwest Community Health Services, Inc., described below.
Southwest Community Health Services, Inc.	Southwest Community Health Services is a for-profit entity, owned by Smyth County Community Hospital, which operates a pharmacy and provides other health services to the residents of Smyth County, VA.
Norton Community Hospital (Norton, VA)	Norton Community Hospital has served Southwest Virginia and Southeastern Kentucky since 1949. The 129-bed, acute care facility provides a full array of services, including emergency services and a variety of inpatient and outpatient services. Norton Community was the first American Osteopathic Association-accredited teaching facility in the commonwealth of Virginia and hosts residents in internal medicine.
Norton Community Physician Services, LLC	Norton Community Physician Services is a for-profit entity consisting of physician practices and pharmacy. NCPS employs 16 physicians and 4 mid-levels to serve the residents of Wise County and surrounding area.
Dickenson Community Hospital (Clintwood, VA)	Dickenson Community Hospital is one of two critical access hospitals operated by Mountain States Health Alliance. The hospital is licensed for 25 beds and provides emergency services and a variety of inpatient and outpatient services to the residents of Dickenson County.

Community Home Care, Inc.	Community Home Care is a home health agency located in Norton City, VA, that provides comprehensive quality care to patients within the comfort of their home.
Johnston Memorial Hospital (Abingdon, VA)	Johnston Memorial Hospital (JMH) is a 116-bed community hospital which was relocated to a new, state of the art facility in 2011. At that time, JMH was recognized as the first Gold Leadership in Energy and Environmental Design (LEED)-certified hospital in Southwest Virginia providing a full array of services, including emergency services and a variety of inpatient and outpatient services.
Abingdon Physician Partners	Abingdon Physician Partners is a physician practice owned and managed by Johnston Memorial Hospital consisting of 16 physicians and 5 mid-levels. JMH is 100% owner of Abingdon Physician Partners.
JMH Emergency Physicians, LLC	Johnston Memorial Hospital Emergency Physicians are fully employed ER physicians providing 24-hour emergency department coverage. JMH is 100% owner of JMH Emergency Physicians, LLC.

Other Mountain States' Entities Mountain States' integrated healthcare delivery system also includes other entities providing a variety of patient care and population health services. The following summaries describe other Mountain States corporate entities and their affiliates/subsidiaries.	
Integrated Solutions Health Network	Mountain States offers advanced population health management services through its subsidiary, Integrated Solutions Health Network (ISHN). ISHN is the corporate parent of AnewCare Collaborative and CrestPoint Health. AnewCare Collaborative is Mountain States' Accountable Care Organization, which operates a 14,000-member Medicare Shared Savings Program. CrestPoint Health operates TPA services for Mountain States team members and a Medicare Advantage Product with more than 5,000 covered lives at the end of 2015.
Mountain States Health Alliance Auxiliary, Inc.	The Mountain States Auxiliary was established in 1979 to provide financial support for various projects, particularly ones involving extra benefits for Mountain States team members, patients, and guests. The Auxiliary operates the Gift Shops and conducts sales of such items as uniforms, jewelry and books.
Blue Ridge Medical Management Corporation	Blue Ridge Medical Management Corporation (BRMMC) is a wholly owned, for-profit subsidiary of Mountain States Health Alliance. BRMMC owns and manages physician practices throughout the service area through its integrated physician organization, Mountain States Medical Group. Mountain States Medical Group includes more than 250 providers in over 90 locations representing 25 specialties, including eight urgent care sites. In addition to Mountain States Medical Group, other business units of BRMMC include Mountain States Properties, a real estate division which owns and manages almost one million square feet of medical office space; HealthPro Staffing, a staffing agency formed to provide staffing solutions to the Mountain States Health Alliance facilities and other healthcare organizations in the region; Medi-Serve Medical Equipment Company, a durable medical equipment and respiratory services company with three locations in Northeast Tennessee and Southwest Virginia; Mountain States Pharmacy, a retail pharmacy with five locations in Northeast Tennessee and Southwest Virginia; The Wellness Center, a health and fitness center; and ownership and investment in a number of joint ventures such as ambulatory surgery centers and urgent care facilities.

Mountain States Foundation	Mountain States Foundation is a not-for-profit entity providing philanthropic support to Mountain States Health Alliance through the coordination of fundraising and development activities. The Mountain States Foundation assisted with fundraising for the Niswonger Children's Hospital, Johnson City Medical Center radiation oncology expansion, and various fundraising opportunities at local facilities throughout the system.

APPLICATION

CERTIFICATE OF PUBLIC ADVANTAGE

STATE OF TENNESSEE

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: February 16, 2016

FEBRUARY, 2016

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1. EXECUTIVE SUMMARY

REQUEST: The Executive Summary shall include:

(i) Goals for change to be achieved by the Cooperative Agreement;

(ii) Benefits and advantages to parties and the public including but not limited to:

(I) Population health;
(II) Access to health care and prevention services; and
(III) Health care operating costs, including avoidance of capital expenditures, reduction in operating expenditures and improvements in patient outcomes.

(iii) Description of how the Cooperative Agreement better prepares and positions the parties to address anticipated future changes in health care financing, organization and accountability initiatives; and

(iv) Potential disadvantages of the Cooperative Agreement.

RESPONSE: Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States") (collectively, the "Parties") are formally submitting this application to the Tennessee Department of Health to request the issuance of a Certificate of Public Advantage ("COPA") under Tennessee Code Section 68-11-1301 *et seq*.

The Process.

Two years ago, Wellmont began an internal evaluation of Wellmont's strategic and financial position, industry trends, and the organization's goals for the future of health care within its service area. Wellmont entered the process from a position of clinical strength and relative financial stability, but recognized that it needed to be prepared for financial pressures, regulatory mandates, and imperatives for change. The important and increased need for investment in population health, management of information and measurable improvement in cost and quality, combined with continued downward pressure on reimbursement from government and commercial payers compelled the Wellmont Board to thoroughly evaluate its strategic options. Wellmont's Board evaluated all reasonable options with the objective of sustaining community assets vital to the region while achieving high quality patient care at the lowest possible cost. Wellmont was not alone. Hospital systems throughout the nation have undergone strategic options reviews, with many choosing a traditional merger or consolidation in hopes of surviving in this challenging environment – an environment which has seen

more than 60 rural hospitals close since 2010.[1] Four of Wellmont's six hospitals are rural, and have below 50 staffed beds, each with a daily census ranging from 3 to 13. Seven of the Mountain States hospitals are rural, and have below 50 staffed beds, each with a census ranging from 1 to 35. The overwhelming number of assets between the two systems are rural.

Providers throughout the nation, including Wellmont and Mountain States, are faced with reduced payment for services, services moving from the inpatient to the outpatient setting, higher patient out-of-pocket costs due to increased copayments and deductibles (resulting in additional declining revenue to the hospitals as the deductibles are increasingly uncollectable by hospitals), and a variety of other pressures stemming from an understandable frustration with the cost of health care. The challenges are intensified in the Parties' service area of Northeast Tennessee and Southwest Virginia, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant health care challenges.

After a thorough evaluation, Wellmont's Board of Directors and leadership team ultimately determined that Wellmont's future would be best served through a strategic alignment with another health care system. In April 2014, Wellmont began a strategic options process to further consider alternatives to fulfill its long-term health care mission through potential alignment options. Wellmont issued requests for proposals from organizations interested in strategic alignment and received substantial interest and a number of proposals from a variety of sophisticated health systems, including Mountain States. Based on inquiries, the health system issued twenty-two requests for proposals and received nine proposals from other health systems. After more than a year of merger discussions, internal analysis within each system, thoughtful conversations in the community and unanimous votes by both boards to examine this option, Wellmont entered into a term sheet with Mountain States in April, 2015 to exclusively explore the creation of a new, integrated and locally governed health system (the "New Health System").

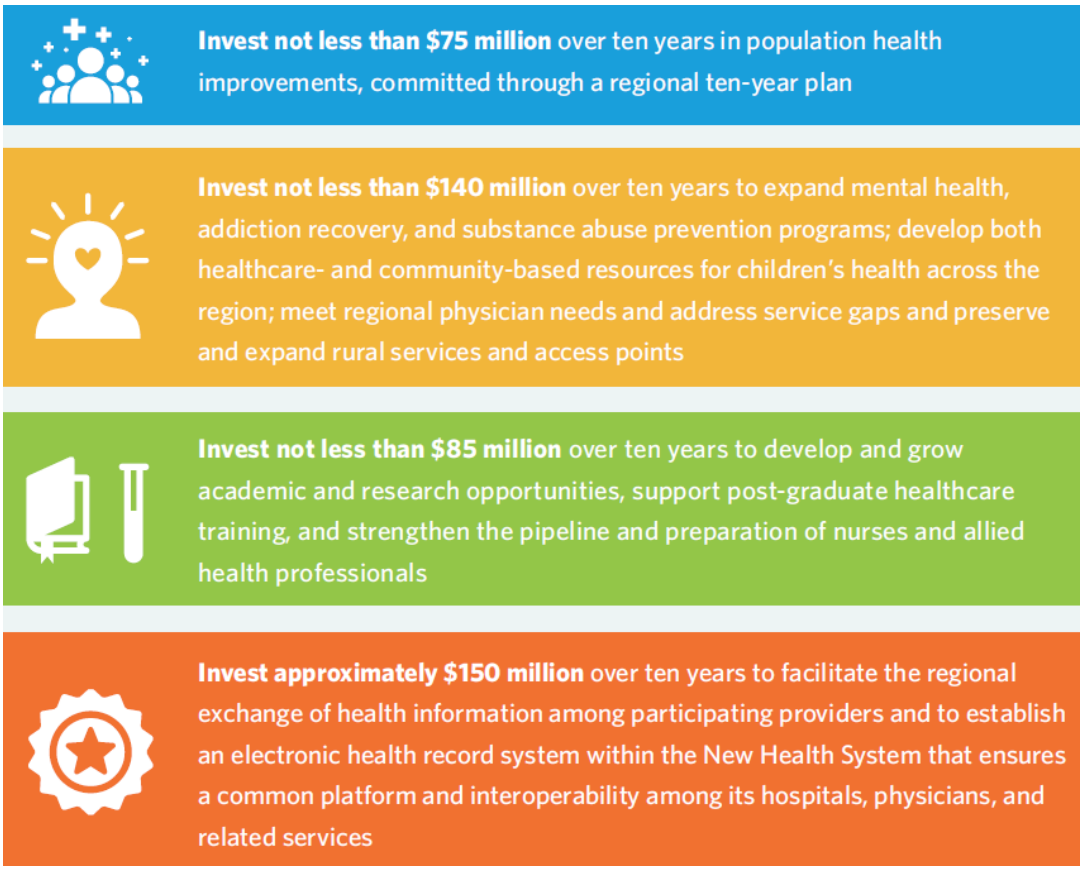
Wellmont and Mountain States have a history of competition dating back to the formation of the two health systems in the late 1990s, and the decision to form the New Health System is not based on a traditional merger approach. This merger is contingent on the granting of a Certificate of Public Advantage by the State of Tennessee and a Letter Authorizing a Cooperative Agreement by the Commonwealth of Virginia (collectively the "State Agreements"). Without the State Agreements, the proposed consolidation of Wellmont and Mountain States, would likely be challenged under state and federal antitrust laws. The Parties believe that this merger is the only model that

[1] *See 66 Rural Hospital Closures: January 2010 – Present, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, available at https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (accessed January 25, 2016).*

effectively maintains local governance, provides a unique opportunity to sustain and integrate health care delivery for residents into a high-quality and cost-effective system, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in the region, and invests those dollars in the improved health of this region while also preserving local jobs.

The Goals to be Achieved by the Cooperative Agreement.

The Parties' goal in pursuing the merger is to reduce cost growth, improve the quality of health care services and access to care, including the patient experience of care, and enhance overall community health in the region. Under approved State Agreements, savings realized through the merger, by reducing duplication and improving coordination, will remain within the region and be reinvested in ways that significantly benefit the community through the addition of new services and capabilities, improved choice and access, effective management of costs and investment in improving the quality of health care and economic development in the region. All of these investments will be devoted to Northeast Tennessee and Southwest Virginia to focus on improving the health of this region's residents and the economy of its communities. As examples, the New Health System will:



The Benefits and Advantages of the Cooperative Agreement.

- Population Health. The New Health System is committed to creating a new integrated delivery system designed to significantly enhance community health through the investment of not less than $75 million over ten years in population health improvement. The New Health System would commence the population health improvement process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for its focus over the next decade. The health improvement plan would be prepared in conjunction with the public health resources available at East Tennessee State University. The funding may be committed to the following initiatives, as well as others, based upon the 10-year action 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.[2]

    - ***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.

- 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 allow the hospitals the opportunity to continue to offer programs and services that are now unprofitable and otherwise may have to be reduced or cancelled due to lack of funding. The New

[2] In May 2010, the Annie E. Casey Foundation published *Early Warning: Why Reading by the End of Third Grade Matters*, which summarized the research basis for focusing on grade-level reading proficiency as an essential step toward increasing the number of children who succeed academically, graduate from high school on time and do well in life and the workforce. http://www.aecf.org/resources/early-warning-confirmed/.

Health System will commit to spending at least $140 million over ten years pursuing specialty services. Specifically, the New Health System will create new capacity for residential addiction recovery services, develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents, ensure recruitment and retention of pediatric sub-specialists, and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals. These 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 thereby contributing to the overutilization of costly inpatient services. The merger offers the New Health System the opportunity to use resources derived from efficiencies and a regionally integrated delivery model 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 merger-derived savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that substantially benefit the community by the addition of new services and capabilities, the New Health System is prepared to make significant commitments related to pricing, consolidation of services, and standardization of practices, all of which are described in more detail in this Application.

- Investment in Health Research and Graduate Medical Education. The New Health System will work with its academic partners to 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. Partnerships with academic institutions will enable research-based and academic approaches to the provision of these services. These initiatives would not be sustainable in the region without the financial support created by the merger.

- Avoidance of Duplication of Hospital Resources. Combining these two health systems in an integrated delivery model is the only 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 moving forward. These efforts will produce savings that may be invested in higher-value activities in the region to help expand currently absent but necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community

health and diversify the economy by adding research opportunities. The coordination, integration, sustainability and development of new models of care delivery made possible by the merger will lead to better health for local residents and a stronger local economy.

- Improvements in Patient Outcomes. The region served by the Parties faces significant health care challenges. A key goal of the Cooperative Agreement is to enable the Parties to sustain and enhance services and improve the quality of health care and patient outcomes. The New Health System is committed to implementing a common clinical information technology platform (the "Common Clinical IT Platform") to allow providers in the New Health System the ability to obtain full access to patient records quickly at 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 approximately $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 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. 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 rural hospital operations in these areas and thus enhance access to quality care in our 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 gaps exist in the continuum of care devoted to these issues. 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.

How the Cooperative Agreement Best Positions the Parties to Address Anticipated Future Changes in Health Care Financing, Organization and Accountability Initiatives.

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, which was enacted in 2010, 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. However, the movement to value-based payment requires comprehensive provider networks to form and contract for the total care of patients for 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. As evidence of its commitment to move towards risk-based payment, the New Health System is willing to: include provisions for improved quality and other value-based incentives for all Principal Payer[3] contracts; discuss risk-based models with its Principal Payers for some portion of each Principal Payer's business; and commit to having a risk-based model in place within two years after the closing of the transaction (the "Closing"), subject to payer interest.

Potential Disadvantages of the Cooperative Agreement.

The Parties do not foresee any adverse impacts on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement. Rather, the Parties foresee the Cooperative Agreement resulting in significant benefits as detailed in this Application.

[3] 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.

A Unique Solution for a Unique Region.

Northeast Tennessee and Southwest Virginia disproportionately suffer from serious health issues.[4] The cost of this poor health is not sustainable. This region is a unique geographic area that requires a unique solution. With the approvals of Tennessee and Virginia under the State Agreements, savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the community. These benefits will include new services and capabilities, improved choice and access; more effective management of health care costs, and strategic investments to address the region's most vexing health problems while spurring its economic development.

The merger of Wellmont and Mountain States is a unique opportunity to create a long-lasting legacy of improved health for this region with positive effects on the local economy.

[4] *C*ounty-level data for the region is available at 2015 "Drive Your County to the Top Ten," Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. *Available at*: https://www.tn.gov/health/topic/specialreports/.

2. IDENTIFICATION OF THE PARTIES

REQUEST: Provide the names of each party to the Application and the address of the principal business office of each party.

RESPONSE:

Legal Name of Applicant #1.

Mountain States Health Alliance
FEIN: 62-0476282

Address of Principal Business Office for Applicant #1.

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

Legal Name of Applicant #2.

Wellmont Health System
FEIN: 62-1636465

Address of Principal Business Office for Applicant #2.

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

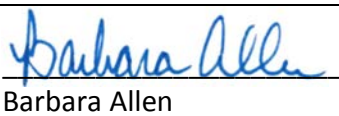
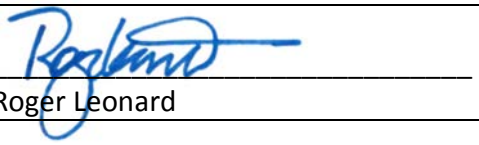
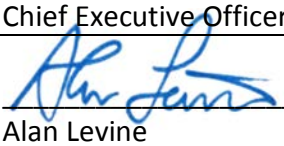
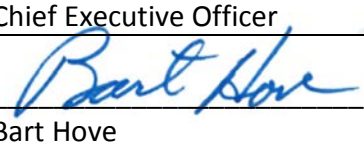
Throughout this Application, the parties listed above are referred to individually as a "Party" and collectively as the "Parties."

3. VERIFIED STATEMENT

REQUEST: Provide a verified statement signed by the Chairperson of the Board of Directors and Chief Executive Officer of each party to the Application; or, if one or more of the Applicants is an individual, signed by the individual Applicant; attesting to the accuracy and completeness of the enclosed information.

RESPONSE: The undersigned hereby verifies that:

a. it is the intent of the parties to enter into the Cooperative Agreement as presented in this application;
b. the parties hereby apply for a Certificate of Public Advantage to govern the Cooperative Agreement; and
c. that the information included in this application and all attachments is accurate and complete to the best of our knowledge and belief and that it is our intent to carry out the proposed agreement.

Mountain States Health Alliance Chairman of the Board		**Wellmont Health System** Chairman of the Board
 Barbara Allen		 Roger Leonard
Mountain States Health Alliance President & Chief Executive Officer		**Wellmont Health System** President & Chief Executive Officer
 Alan Levine		 Bart Hove

4. PRIOR HISTORY OF APPLICANTS

REQUEST: Provide a description of the prior history of dealings between the parties to the Application, including, but not limited to, their relationship as competitors and any prior joint ventures or other collaborative arrangements between the parties.

RESPONSE:

Description of Mountain States Health Alliance

Mountain States Health Alliance ("Mountain States") is a Tennessee non-profit corporation based in Johnson City, Tennessee. It traces its roots back over one hundred years, and became a system in 1998 when the then Johnson City Medical Center Hospital, Inc., a one-hospital organization, acquired from the former Columbia-HCA six hospitals located in upper East Tennessee, thus forming Mountain States. In 2006 Mountain States acquired a membership interest in Smyth County Community Hospital in Marion, Virginia, which began Mountain States' journey as a multi-state health care system. Since 2006, Mountain States has acquired or become a member of four other hospitals in the Southwest Virginia region.

Throughout its multi-state service area, Mountain States functions as an integrated delivery system. Its thirteen hospitals collectively offer a range of services from the most basic primary level of care through two critical access facilities to highly advanced tertiary levels of care such as Level I trauma, open heart and radiation oncology. Through its for-profit subsidiaries, Mountain States employs approximately four hundred physicians and mid-level providers throughout the region. Also, Mountain States, either directly or through its for-profit subsidiaries, provides an array of outpatient and/or post-acute care services, including: pharmacy; home health; hospice; durable medical equipment; diagnostics; skilled nursing/nursing home; and rehabilitation. Additionally, Mountain States owns and operates the region's only children's hospital: Niswonger Children's Hospital.

Mountain States' hospitals provide services with a total licensed bed complement of 1,669 beds[5] but with an average daily census of 734 for FY2013. The Tennessee hospitals owned and/or operated by Mountain States are: Johnson City Medical Center; Niswonger Children's Hospital;[6] Indian Path Medical Center; Franklin Woods Community Hospital; Sycamore Shoals Hospital; Unicoi County Memorial Hospital; Johnson County Community Hospital; and Woodridge Hospital.[7] Mountain States also has a joint venture with HealthSouth to operate Quillen Rehabilitation Hospital where 26 rehab beds

[5] This number includes Mountain States' general acute care beds, psychiatric beds, rehab beds, nursing home beds and skilled nursing beds.
[6] Niswonger Children's Hospital is licensed under Johnson City Medical Center.
[7] Woodridge Hospital is also licensed under Johnson City Medical Center.

currently exist. In Virginia, Mountain States owns and/or operates: Johnston Memorial Hospital; Smyth County Community Hospital; Russell County Medical Center; Norton Community Hospital and Dickenson Community Hospital. Mountain States also holds an ownership interest in a number of joint venture entities, primarily for the purpose of providing ambulatory surgical services. None of these joint ventures include Wellmont Health System.

Description of Wellmont Health System

Wellmont Health System ("Wellmont") is a Tennessee non-profit corporation based in Kingsport, Tennessee, and provides health care services in Northeast Tennessee and Southwest Virginia. Wellmont was formed in July 1996 with the merger of Bristol Memorial Hospital, now known as Bristol Regional Medical Center, in Bristol, Tennessee and Holston Valley Medical Center in Kingsport, Tennessee. Since that time, Wellmont has grown to include four additional rural hospitals, an integrated physician network and several ambulatory sites. Wellmont hospitals offer a broad scope of services, including community-based acute care to highly specialized tertiary services including two trauma centers, comprehensive heart care and cancer care.

Wellmont owns and operates an integrated health care delivery system providing inpatient, outpatient and other health care services at multiple locations in Northeast Tennessee and Southwest Virginia. Currently, Wellmont owns and operates five acute care hospital facilities and one critical access hospital with a total of 1,011 licensed beds but with an average daily census of 430 for FY2013. The Tennessee hospitals owned/operated by Wellmont in Tennessee include: Holston Valley Medical Center; Bristol Regional Medical Center; Hawkins County Memorial Hospital; and Hancock County Hospital. In Virginia, Wellmont owns and/or operates: Mountain View Regional Medical Center and Lonesome Pine Hospital.

Wellmont also, directly or indirectly, controls, owns or is affiliated with various nonprofit and for-profit corporations and other organizations that currently provide health care and health care-related services throughout the service area.

History of Dealings between the Parties

Wellmont and Mountain States have competed with each other in certain areas and with other health care providers since the formation of the two systems in the late 1990s. Prior to the merger of Holston Valley and Bristol Regional into Wellmont and the acquisition of HCA hospitals by Johnson City Medical Center, which formed Mountain States, those three tertiary facilities were viewed largely as serving their individual cities and adjacent areas. Since the formation of the two systems, each system subsequently acquired smaller primary and secondary facilities, and has served a region composed of twenty-one counties in southwestern Virginia and northeastern Tennessee. The two systems offer essentially equivalent levels of services in their respective tertiary and

secondary hospital facilities. In addition, both systems have historically affiliated with separate air ambulance services and operate competing Level I Trauma Centers. In addition, Wellmont has a Level II Trauma Center located in Northeast Tennessee, which is the only region of the state having more than one Level I trauma center. Although there is some overlap in the primary market areas of the three large tertiary facilities, the main overlap in competitive services has occurred in two areas: (1) Wise County, Virginia, where Wellmont owns two secondary acute care hospitals and Mountain States owns one hospital; and (2) Kingsport, Tennessee, where Mountain States' secondary acute care facility Indian Path Medical Center competes with Holston Valley Medical Center, Wellmont's largest tertiary facility.

In the early 2000s, Wellmont applied for and initially was awarded a certificate of need ("CON") to construct a secondary hospital facility in Johnson City, but that CON was overturned following a challenge to the CON by Mountain States. Wellmont's 2007 CON application for a free-standing Emergency Room to be located on the northern boundary of Johnson City was denied following opposition by Mountain States. Beginning in 2012, Wellmont and Mountain States competed in a public contest for the acquisition of Unicoi County Memorial Hospital; ultimately, Mountain States acquired that facility in 2013.

The Parties have attempted to collaborate with respect to quality improvement methodologies and related projects but have been unsuccessful due to the competitive environment, the inability to share proprietary information, and the lack of a common clinical information system.

There have also been examples of cooperative arrangements between the Parties as follows:

- In 2004, the foundations for the two systems worked together to start the first regional Susan G. Komen affiliate.

- For several years now, hospitals from both systems have been members of the Northeast/Sullivan Healthcare Coalition to utilize annual grant funds from the Tennessee Department of Health to prepare the region for disasters and health emergencies. The two health systems are currently alternating annually as fiscal agents for the $250,000 per year in grant funds for this project.

- Since 2008, Wellmont has provided blood services to certain Mountain States facilities through its blood bank, the Marsh Regional Blood Center.

- The two systems collaborated in 2014 in their joint responses to the Ebola awareness and preparedness campaigns and have jointly sponsored other community health awareness efforts, such as the Healthy Kingsport initiative.

- Recently, Wellmont has added Indian Path Medical Center as a satellite site to its Orthopedic Residency Program and has allowed Mountain States/Norton Community Hospital Internal Medicine residents the opportunity to complete their endocrinology rotations at Bristol Regional Medical Center.

- Also, the two systems are currently working together to provide an Antibiotic Stewardship educational program for providers and the community.

- In addition, in cooperation with the College of Public Health at East Tennessee State University ("ETSU") and in connection with the parties' goal to improve health care services through a cooperative agreement, the parties have jointly sponsored and funded the region's most substantial community health improvement assessment effort to date. Four Community Health Work Groups have been created to specifically focus on the health needs in the region, including Mental Health and Addiction, and Healthy Children and Families. Numerous public meetings have been held to seek community input. Mutual efforts directly related to this proposed merger are discussed more fully herein in **Section 8.G**.

5. PROPOSED GEOGRAPHIC SERVICE AREA

REQUEST: Provide a detailed description of the proposed geographic service area, not limited to the boundaries of the State of Tennessee. If the proposed geographic service area differs from the service areas where the parties have conducted business over the five years preceding the Application, a description of how and why the proposed geographic service area differs and why changes are proposed.

RESPONSE: The proposed Geographic Service Area takes into consideration the counties principally served by the Parties, including the following counties: Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee; Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina; Harlan and Letcher in Kentucky, and Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe in Virginia. These counties represent the service areas where the Parties have conducted business over the five years preceding the Application. These counties are inclusive of the areas from which the Parties draw and serve the majority of patients. While the Parties serve patients from twenty-nine counties in Tennessee, Virginia, North Carolina, and Kentucky, the patients only receive services from Wellmont and Mountain States at facilities and locations in Tennessee and Virginia, as the Wellmont and Mountain States physical facilities and provider locations are all in those two states and are subject to state regulations only in these states. To the extent the Parties draw some patients from adjacent North Carolina and Kentucky counties, these patients are served at the Parties' facilities and provider locations in Tennessee and Virginia.

In defining the Geographic Service Area for purposes of this Application and specifically for responses to a broad range of questions that request a single geographic area, the Parties believe it appropriate to focus on an area of the twenty-one counties in Tennessee and Virginia.[8] This is inclusive of the Tennessee and Virginia counties in which the Parties have locations and facilities and serve residents, and all locations and providers that will be under the control of the Parties and subject to any regulation under the COPA or Cooperative Agreement. This area is inclusive of most of the population, whether commercial, Medicare, Medicaid, or uninsured, served by the Parties.

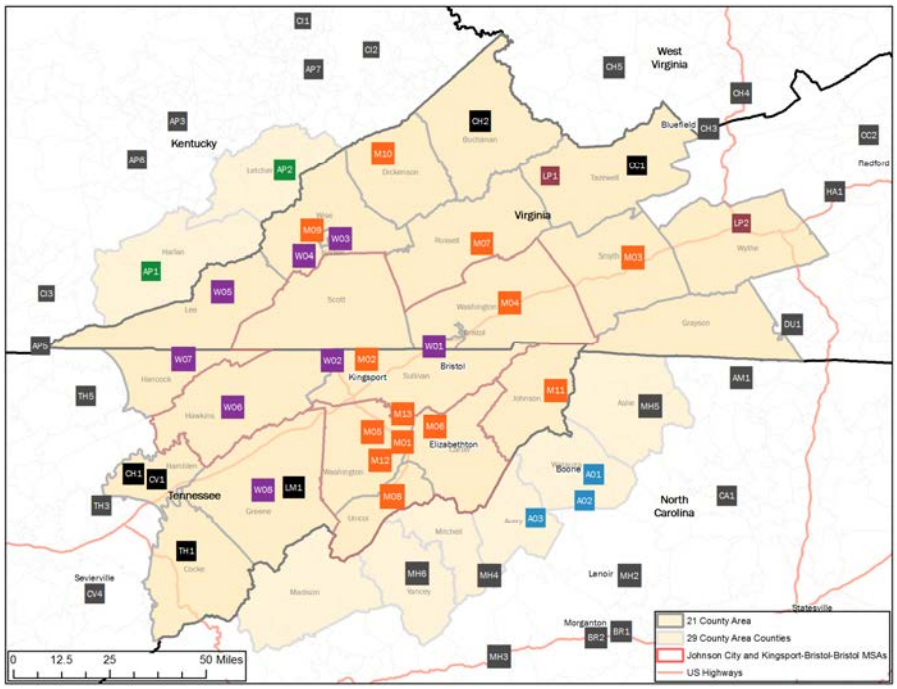
The Parties expect that the benefits of the transaction will primarily accrue in the Tennessee and Virginia counties and will likely extend to residents and communities in the adjacent North Carolina and Kentucky communities primarily through their access of services in Tennessee and Virginia. These benefits are likely to derive substantially from the changes made possible by the transaction at the facilities and provider locations of

[8] These 21 counties are: Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee and Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe (including the Independent Cities of Bristol and Norton) in Virginia.

the New Health System located in Tennessee and Virginia, as well as the investments made by the New Health System in this region.

For purposes of the analyses in this Application, including share analysis and identification of competitors, the Parties focus on the twenty-one county area in Virginia and Tennessee principally served by the Parties, including the independent cities of Bristol and Norton in Virginia (the "Independent Cities"), and refer to this area throughout the Application as the "Geographic Service Area." **Figure 5.1** is the map of the Geographic Service Area indicating the location of hospitals and highlights the twenty-one (21) counties in Tennessee and Virginia.

Figure 5.1 - Map of the Geographic Service Area[9]



Rural Population: The Geographic Service Area within Virginia and Tennessee has a population over 960,000. Its largest cities are Bristol, Kingsport, and Johnson City. In the

[9] An enlarged version of the map and the legend are attached as **Exhibit 5.1**. Wellmont closed Lee Regional Medical Center ("LRMC") in 2013. The Lee County Hospital Authority purchased the LRMC building from Wellmont in 2015 with plans to reopen the hospital as an independent facility. LRMC is no longer a Wellmont facility and, if reopened, it would not be included in the COPA. Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA. For purposes of this map, Takoma (W08) is counted as one of the independent hospitals. The Mountain Home VA Medical Center is also located in the Geographic Service Area but is not shown on this map. The Parties compete with this facility for the recruiting and hiring of staff, but do not compete with this facility for patients. The patients that may seek treatment at the Mountain Home VA Medical Center are limited to those individuals that meet certain government-established criteria.

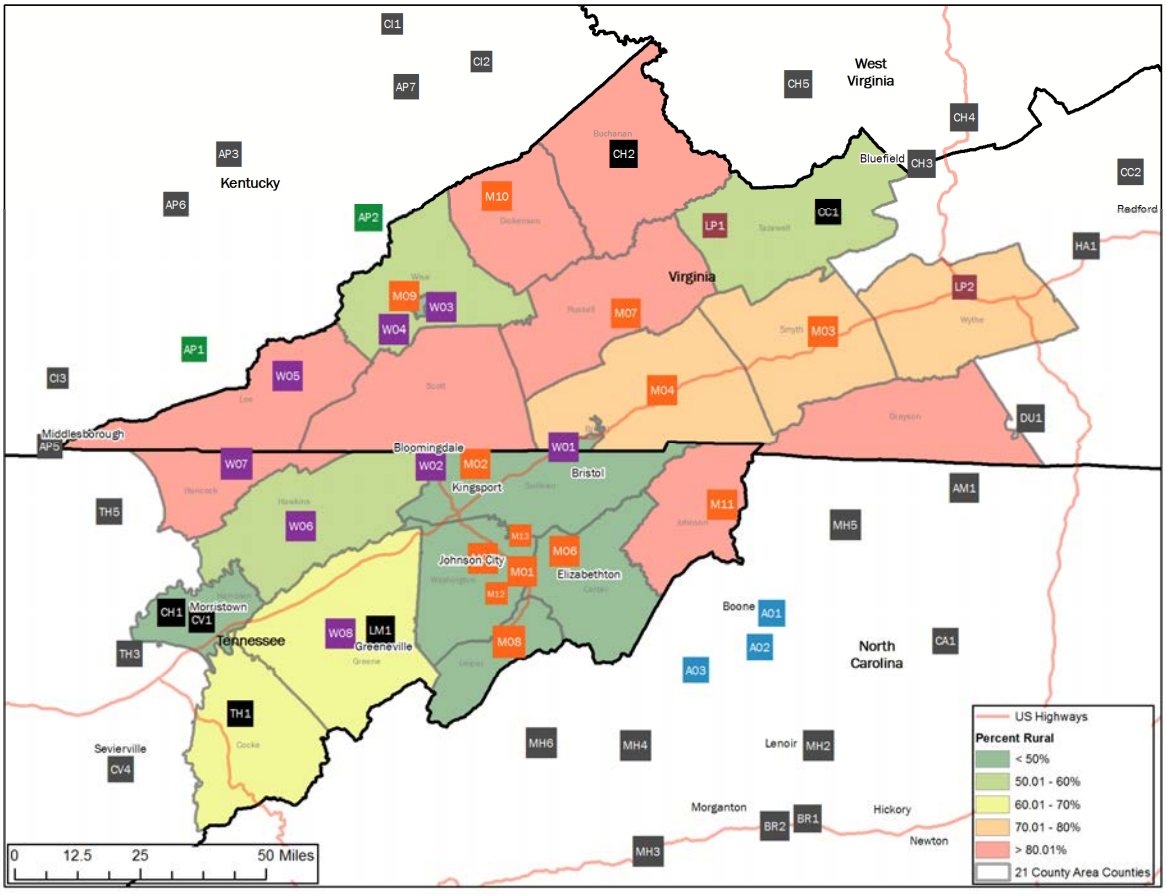
Geographic Service Area, over 500,000 residents (52%) live in areas defined as rural. **Table 5.1** provides data on population, the proportion of the county/Independent Cities in the Geographic Service Area classified as rural, and the total "rural" population.[10] The data reveal that many of the counties/Independent Cities in the Geographic Service Area served by Wellmont and Mountain States are predominantly rural. Even in the two most populous counties (Washington and Sullivan Counties in Tennessee) a quarter or more of the population resides in rural areas. In total, sixteen of the counties in the Geographic Service Area (excluding the Independent Cities) are more than 50% rural, and in five counties virtually all of the population is classified as rural. **Figure 5.2** is a map with counties shaded by proportion of the population that is rural; it indicates that most of the Virginia counties are predominantly rural, as are all but a few counties in and around Sullivan and Washington Counties in Tennessee.

Table 5.1 – Geographic Service Area Statistics

County Name	Total Population	Percent Rural	Rural Population
Grand Total	***962,309***	***52.0%***	***500,270***
Hancock, TN	6,819	100.0%	6,819
Buchanan, VA	24,098	100.0%	24,098
Dickenson, VA	15,903	100.0%	15,903
Grayson, VA	15,533	99.9%	15,514
Lee, VA	25,587	99.6%	25,475
Russell, VA	28,897	88.2%	25,483
Johnson, TN	18,244	85.2%	15,546
Scott, VA	23,177	82.1%	19,034
Smyth, VA	32,208	75.3%	24,248
Wythe, VA	29,235	75.3%	22,023
Washington, VA	54,876	71.7%	39,333
Cocke, TN	35,662	67.5%	24,083
Greene, TN	68,831	65.2%	44,874
Hawkins, TN	56,833	57.9%	32,884
Wise, VA	41,452	56.7%	23,491
Tazewell, VA	45,078	51.9%	23,390
Unicoi, TN	18,313	44.7%	8,180
Carter, TN	57,424	41.0%	23,524
Washington, TN	122,979	26.4%	32,493
Sullivan, TN	156,823	25.6%	40,086
Hamblen, TN	62,544	21.9%	13,680
Norton City, VA	3,958	2.6%	102
Bristol City, VA	17,835	0.0%	7

[10] All reported measures were obtained from the US Department of Health and Human Services' Area Health Resource File, a dataset that compiles data collected by other entities; *available at*: http://ahrf.hrsa.gov/. Total Population is from the U.S. Census Bureau's 2010 Census Redistricting Data (Public Law 94-171) Summary File. Rural residency is available from the Census of Population and Housing: Summary File 1 (SF1) Urban/Rural update.

Figure 5.2 - Percentage of Population in Rural Areas



Characteristics of Hospitals: Many of the Parties' hospitals are small, rural, have only a few beds and experience a very small average daily census. The service area and comparative statistics for Wellmont and Mountain States hospitals are attached in **Exhibit 5.1.** It illustrates that many Wellmont and Mountain States hospitals have a narrow service area (defined as comprising relatively few zip codes from which the hospital draws 75-90% of its patients), low staffed bed count and very low average daily census. Several of these hospitals have experienced declines in admissions, occupancy rates and average daily census over the last few years. Moreover, there is very little overlap in the geographic service areas of the smaller Wellmont hospitals and the smaller Mountain States hospitals.

Tables 5.2 and 5.3 demonstrate that licensed bed capacity is a poor measure of actual bed utilization. Most Mountain States and Wellmont hospitals have staffed beds that are well below their licensed bed capacity, and some of those hospitals, have relatively low occupancy rates for staffed beds.

- **Wellmont Bed Size and Average Daily Census**: As of 2013[11], four of the six operating Wellmont hospitals have fewer than fifty staffed beds, and an average daily census from only three to thirteen patients per day. The largest of these small hospitals (Hawkins County Memorial Hospital) has an occupancy rate of only nineteen percent (19%).
- **Wellmont Occupancy Rates:** Occupancy rates fell over the period FY10-FY13 at both Holston Valley and Mountain View Regional. The average daily census and patient days have declined by more than fifty percent (50%) since FY10 at Lonesome Pine.

Table 5.2 - Wellmont Hospitals (2013)

Hospital	Staffed Beds	Licensed Beds	Staffed Beds Occupancy	Licensed Beds Occupancy	Average Daily Census
Holston Valley	339	505	66.4%	44.6%	225
Bristol Regional	261	312	65.0%	54.4%	170
Hawkins County	46	50	18.7%	17.2%	9
Lonesome Pine	21	60	49.6%	17.4%	10
Mountain View Regional	18	74	69.5%	16.9%	13
Hancock County	10	10	30.9%	30.9%	3

- **Mountain States Bed Size and Average Daily Census**: As of 2013, seven Mountain States hospitals have fifty or fewer staffed beds (three have fewer than ten staffed beds) and an average daily census ranging from thirty-five to less than one patient per day on average. Four other Mountain States hospitals have between seventy-four and one hundred twelve staffed beds and an average daily census ranging from forty-two to sixty-five patients.
- **Mountain States Occupancy Rates**: Several Mountain States hospitals have low staffed bed occupancy rates. The average daily census at the Dickenson Community and Johnson County Community hospitals has been less than one each year since FY10.

[11] These numbers do not include Takoma Regional Hospital in the Wellmont numbers. Takoma was sold by Wellmont in 2014.

Table 5.3 - Mountain States Hospitals (2013)

Hospital	Staffed Beds	Licensed Beds	Staffed Beds Occupancy	Licensed Beds Occupancy	Average Daily Census
Johnson City[12]	497	501	69.3%	68.7%	344
Indian Path	168	239	37.4%	26.3%	63
Johnston Memorial	112	116	58.3%	56.3%	65
Woodridge Psychiatric	80	84	76.0%	72.4%	61
Franklin Woods	77	80	54.1%	52.1%	42
Sycamore Shoals	74	121	57.0%	34.9%	42
Norton Community	50	129	70.5%	27.3%	35
Russell County	49	78	58.5%	36.7%	29
Smyth	44	44	48.1%	48.1%	21
Quillen Rehabilitation[13]	26	26	77.8%	77.8%	20
Unicoi County	7	48	169.7%	24.7%	12
Dickenson Community	2	25	1.6%	0.1%	<1
Johnson County	2	2	6.0%	6.0%	<1

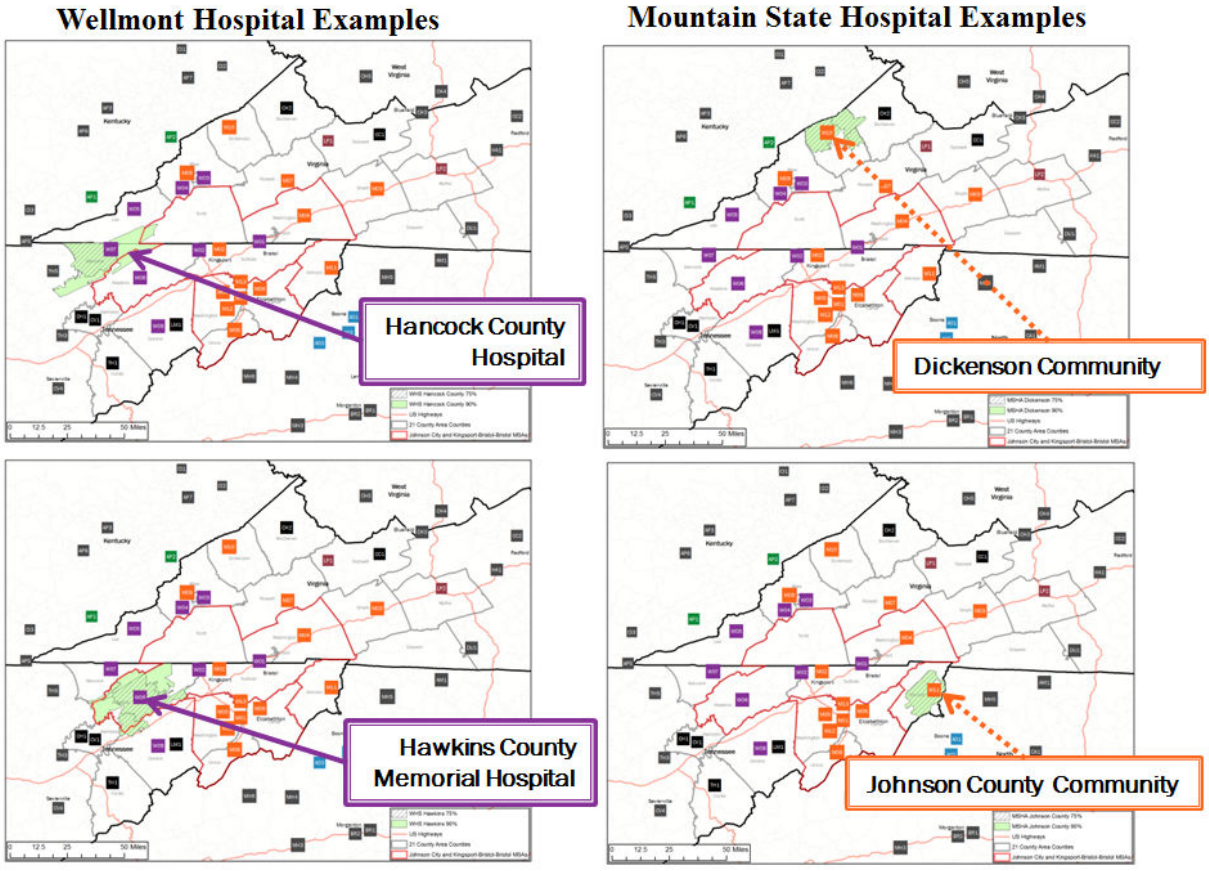
Service Areas: Several of the smaller Wellmont and Mountain States hospitals have narrow, non-overlapping service areas. The maps in **Figure 5.3** below show the 75% and 90% draw areas for certain Wellmont and Mountain States hospitals.[14] Dickenson Community's 75% and 90% draw areas comprise only three ZIP codes and Johnson County Community's 75% and 90% draw areas consist of only a single zip code. In general, Wellmont hospitals tend to be on the western side of the Geographic Service Area and Mountain States hospitals tend to be in the northeast, south or southeast areas.

[12] Niswonger Children's Hospital operates as a unit of Johnson City Medical Center and its data is included in the Johnson City Medical Center reported data.

[13] Mountain States has a minority interest in a joint venture with HealthSouth to operate Quillen Rehabilitation Hospital where 26 rehab beds currently exist.

[14] **Exhibit 5.1** contains the methodology and maps for the 75% and 90% draw areas for each hospital, based on CY2014 discharge data for all payers for Tennessee and Virginia; the 75% area is depicted by cross-hatched areas.

Figure 5.3 - Draw Area Maps



Assessment of Inpatient Services in the Geographic Service Area

Wellmont and Mountain States obtain the majority of their inpatient discharges from the Geographic Service Area, an area served by other hospitals physically located in the area as well as by hospitals located outside of the area. Share analyses of general acute care inpatients in this area were calculated for the New Health System and for its competing hospitals and are shown in **Exhibit 5.2**.[15] There are numerous competing hospitals that collectively account for approximately twenty-five percent (25%) of current discharges of residents in the Geographic Service Area.

The combined share of Wellmont and Mountain States, however, obscures the fact that the majority (58%)[16] of their combined share is accounted for by three hospitals -- Bristol Regional, Holston Valley, and Johnson City Medical Center. Each of the other

[15] Share analyses are based on discharges by hospitals for the Geographic Service Area. **Exhibit 5.2** provides shares calculated excluding DRG 795 and inclusive or exclusive of MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders). The percentage holds for both.

[16] This percentage is lower when MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders) are excluded from the calculation.

Wellmont and Mountain States hospitals, most of which are very small and located in outlying areas,[17] *individually* has very low patient volume and contributes very little to the Parties' combined shares - typically just one to two percent (1-2%) per hospital. The collective volume of these hospitals obscures their very small size and patient volumes thereby overstating any competitive significance.

Some residents of the Geographic Service Area leave the region to receive specialized care. The top three service lines with the largest proportion of outmigration volume from the Geographic Service Area are Mental Diseases, Circulatory, and Musculoskeletal. When patients leave the Geographic Service Area for medical care, they most frequently go to the University of Tennessee Medical Center in Knoxville and Carilion Medical Center in Roanoke, Virginia. Peninsula Hospital in Louisville, Tennessee, receives the largest outmigration for Mental Diseases.

As a result of the Cooperative Agreement, the Parties plan to provide new and enhanced services that will better serve local patients who currently leave the Geographic Service Area for health care and encourage in-migration by patients who reside outside the area. The proposed merger will produce savings that will be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise could not be supported in a region of this size, geography and population density. These are discussed more fully below.

[17] The next largest share contributors are Johnston Memorial Hospital and Indian Path Medical Center, which contribute 8.7% and 6.4% respectively.

6. SERVICES BEING OFFERED BY OTHER PROVIDERS IN THE GEOGRAPHIC SERVICE AREA

REQUEST: Identify whether any services or products of the proposed Cooperative Agreement are currently being offered or capable of being offered by other providers or purchasers in the geographic service area described in the Application.

RESPONSE: As described in more detail below, the Parties' provision of general inpatient services, physician services, and outpatient services are also currently offered or capable of being offered by other providers in the service area. In fact, independent providers offer the majority of physician services (70%) and outpatient services (over 50%).

Inpatient Services. Nine general acute care hospitals in the Geographic Service Area are not operated by Wellmont or Mountain States: Clinch Valley Medical Center, Wythe County Community Hospital, Carilion Tazewell Community Hospital, Lakeway Regional Hospital, Buchanan General Hospital, Morristown-Hamblen Healthcare System, Newport Medical Center, Takoma Regional Medical Center, and Laughlin Memorial Hospital.

The general inpatient services currently offered by Wellmont and Mountain States are offered by, or capable of being offered by, other hospitals located in the Geographic Service Area, with the exception of certain high-level tertiary care services such as trauma and neonatal intensive care.

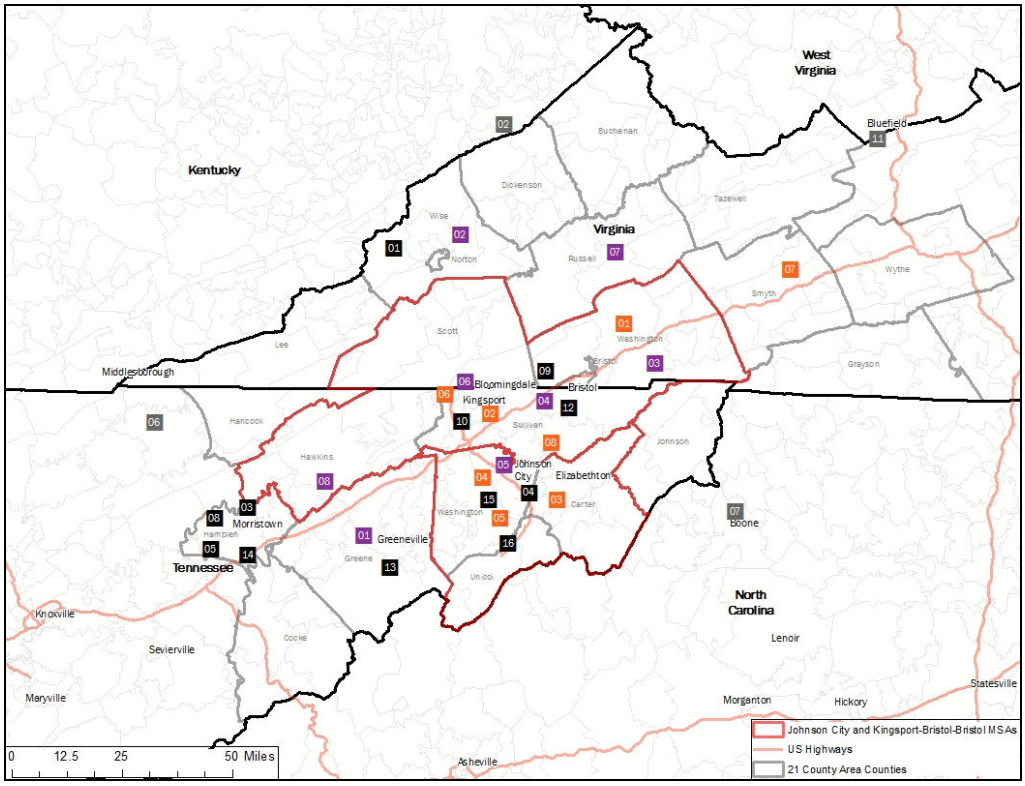
The proposed merger will produce savings to be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise could not be supported in a region of this size, geography and population density. These are discussed more fully below.

Outpatient Facilities. The Geographic Service Area also contains a number of competing, independent outpatient facilities, along with independent nursing homes, assisted living facilities and skilled nursing facilities. **Exhibit 6.1A** provides the numbers and shares of outpatient facilities serving the Geographic Service Area as organized in broad categories.[18] Wellmont and Mountain States together account for less than fifty percent (50%) of the outpatient facilities in twenty-one of the thirty-two categories provided, including Physical Therapy (6.6%) and Nursing Homes (7.6%). Outpatient services including urgent care, imaging, and ambulatory surgery centers have many independent alternatives, which are identified in **Exhibit 6.1A** and whose locations are shown on maps in **Figures 6.1-6.3**. Of the thirty-two urgent care centers in the service area, Mountain States and Wellmont collectively operate sixteen of them; fifty percent (50%) of the urgent care centers are competitor facilities. **Exhibit 6.1B** contains a list of all urgent care facilities serving the Geographic Service Area.[19]

[18] The outpatient facilities listed in **Exhibit 6.1A** include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

[19] The outpatient facilities listed in **Exhibit 6.1B** include the outpatient facilities located in the Geographic Service

Figure 6.1 – Map of Locations of Urgent Care Facilities[20]



The Geographic Service Area contains imaging facilities, including providers of CT, MRI, and X-Ray services. Wellmont and Mountain States each offers at least one type of these imaging services, but over seventy percent (70%) of all imaging facilities in the service area are operated by competitors. Wellmont and Mountain States together account for about half of the CT and MRI capabilities in the Geographic Service Area, and a much smaller percentage of X-Ray capabilities. A breakdown is provided in **Table 6.1** and locations are depicted on the map in **Figure 6.2**. **Exhibit 6.1C** lists all CT/MRI capabilities serving the Geographic Service Area.[21]

Area and serving the Geographic Service Area.

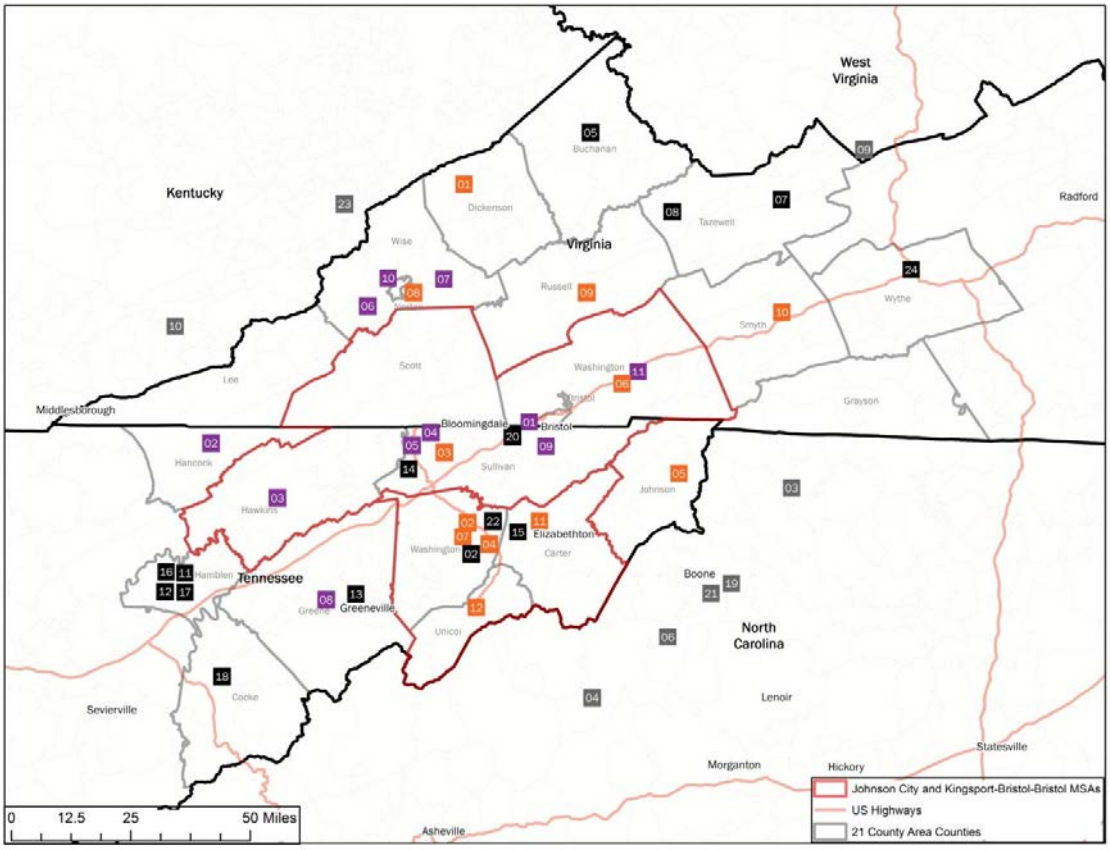
[20] An enlarged version of the map and the legend are attached as **Exhibit 6.1B**.

[21] The outpatient facilities listed in **Exhibit 6.1C** include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

Table 6.1 – Medical Imaging Facilities and System Affiliation in the Geographic Service Area

System Affiliation	Total Facilities[22]	% of Total	CT Capabilities	MRI Capabilities	X-Ray Capabilities
Total	119		43	41	92
Wellmont	18	15.1%	10	7	12
Mountain States	15	12.6%	12	11	14
All Other	86	72.3%	21	23	66

Figure 6.2 – Map of Location of CT/MRI Facilities[23]



Wellmont and Mountain States each have ambulatory surgery centers ("ASCs")[24] in the area, but fifty-seven percent (57%) are competing facilities. The locations of all area

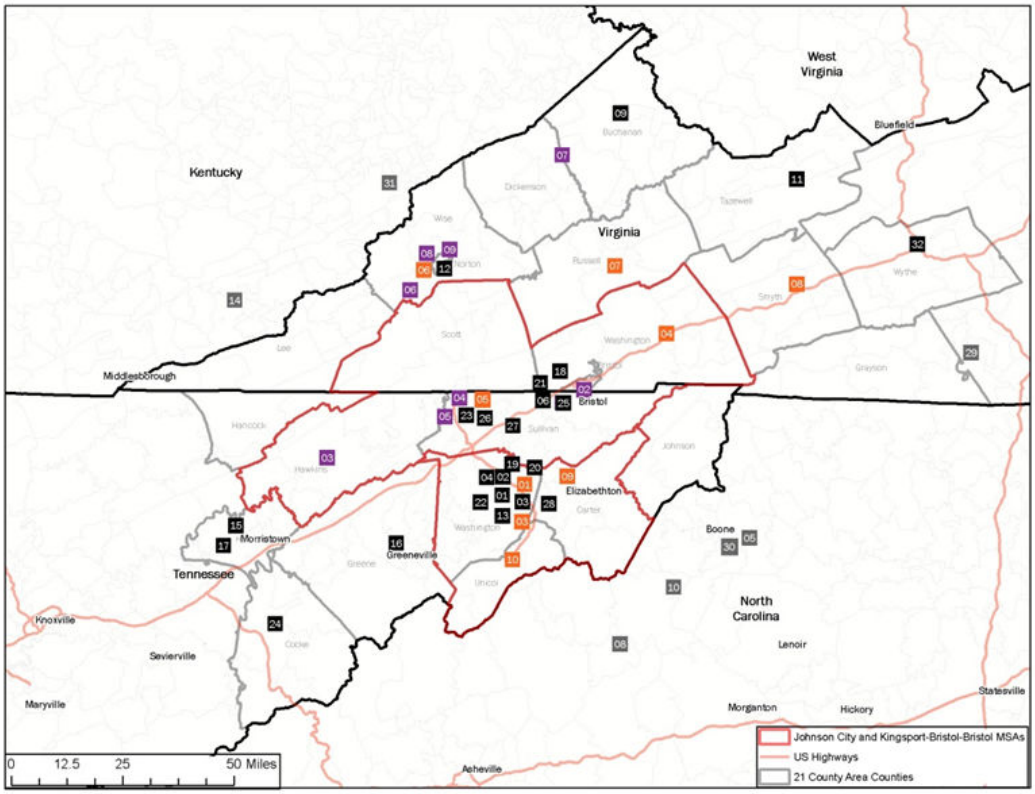
[22] Facilities may have CT, MRI, and/or X-ray capabilities co-located at a single location which are counted separately.

[23] An enlarged version of the map and the legend are attached as **Exhibit 6.1C**.

[24] ASCs include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.

ASCs are shown in **Figure 6.3** below. **Exhibit 6.1D** lists all ASCs serving the Geographic Service Area.[25]

Figure 6.3 – Map of Location of Ambulatory Surgical Centers[26]



Physician Services**.** A large number of independent physicians in the Geographic Service Area offer the physician services currently offered by Wellmont and Mountain States through their respective employed (or affiliated) physicians.

Exhibit 6.1E provides data on the number of physicians employed by Wellmont and employed by or affiliated with Mountain States in each of several specialties (e.g., family practice). It also reports data on the number of independent physicians in each of these specialties; the total counts of physicians are based on all physicians with privileges at either or both of Mountain States and Wellmont.

The majority of physicians in the Geographic Service Area with privileges at Wellmont or Mountain States are independent. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. Wellmont employs nine percent (9%); Mountain States employs seventeen percent (17%); and four percent (4%) of physicians are affiliated with Mountain States through staffing arrangements for

[25] The outpatient facilities listed in **Exhibit 6.1D** include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.
[26] An enlarged version of the map and the legend are attached as **Exhibit 6.1D**.

certain hospital-based services. Independent competitive alternatives exist in all nineteen physician specialties in which the Parties overlap. The combined share of independent physicians exceeds sixty-five percent (65%) in all specialties except Family Medicine, Orthopedic Surgery, Psychology, Psychiatry, Pain Management, Cardiothoracic Surgery, Pulmonology, Occupational Medicine, Hematology/Oncology, Cardiology, and Hospital Medicine, and is at least fifty percent (50%) in most specialties. Nearly sixty-five percent (65%) of Family Practice and Orthopedic physicians are independent.

Each physician specialty where there is an "overlap" between Wellmont and Mountain States includes competition from independent physicians. No overlap between the Parties exists in a large number of specialties and all of them have numerous competitive alternatives. There are relatively few specialties where the combined number of Mountain States and Wellmont employed physicians exceeds thirty-five percent (35%) of the total number of area physicians in that specialty. As is common across the country, certain specialties tend to have higher shares of employed physicians due to the nature of that medical practice. This includes hospitalists, cardiologists and hematologists/oncologists, although these specialties have a number of independent alternatives.

7. ASSURANCE OF CONTINUED COMPETITIVE OPERATION

REQUEST: Explain how the Cooperative Agreement will assure continued competitive and independent operation of the services or products of entities not a party to the Cooperative Agreement.

RESPONSE: Market power will not be gained as a result of the Cooperative Agreement. The New Health System will be actively supervised by Tennessee and Virginia officials. This supervision will ensure that the New Health System will act in furtherance of the public policies that underlie Tennessee's Certificate of Public Advantage and Virginia's Cooperative Agreement statutory and regulatory provisions. Moreover, as noted above, the New Health System will face competition from several independent general acute care hospitals, outpatient facilities, post-acute care facilities and physicians in the Geographic Service Area. These competitors will not be a party to the Cooperative Agreement and the Parties anticipate that they will continue to operate independently and competitively if the COPA is granted. Most outpatient medical services are delivered outside the hospital setting by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, long-term care services, skilled nursing, physical therapy, occupational therapy, pharmacy, counseling, and surgery centers. Wellmont and Mountain States are required to ensure patient choice when selecting these services and will continue these policies as a merged organization.

In order to ensure continued competitive and independent operation of the services and products of entities not a party to the agreement, the Parties are willing to enter into the following commitments.

COMMITMENTS

- 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.
- The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.
- The New Health System will not engage in "most favored nation" pricing with any health plans.

* 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.

Similarly, a large number of independent physicians in the community will not be a party to the Cooperative Agreement. Both Wellmont and Mountain States continue to value a robust and successful independent physician community. The New Health System intends to collaborate where possible with the independent physician community in procompetitive arrangements to build an array of service offerings that will be accessible throughout the region. To remove barriers to patient choice and promote open physician practice, the New Health System is prepared to make the following commitments.

COMMITMENTS

- The New Health System will maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available in close proximity to where the population lives.

- The New Health System will maintain open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the New Health System's Board of Directors.

- The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the New Health System's Board of Directors.

- The New Health System will not require independent physicians to practice exclusively at the New Health System’s hospitals and other facilities.

- The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.

8. STATEMENT ON PUBLIC ADVANTAGE

REQUEST: Provide a statement of whether there will be a Public Advantage or adverse impact on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement.

RESPONSE:

PUBLIC ADVANTAGE

A. Enhancement of the quality of hospital and hospital-related care provided to Tennessee citizens.

The region served by the Parties to the Cooperative Agreement faces significant health care challenges. For example, a 2015 Tennessee Department of Health report[27] 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 birthweight 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, childhood poverty, and death rates due to drug poisoning. Full County Health Rankings for all Tennessee and Virginia Counties and Independent Cities located in the Geographic Service Area are attached as **Exhibit 8.1A** and **8.1B**.

[27] "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available here: https://www.tn.gov/health/topic/specialreports

Table 8.1 - Geographic Service Area Health Rankings

Service Area Health Rankings By State, County or City	Overall State or County Health Rank	Percentage of Adults Reporting Fair or Poor Health	Percentage Of Adults That Are Obese	Percentage of Adults Who Are Currently Smokers	Percentage of Children In Poverty	Drug Poisoning Mortality Rate per 100,000 Population
Tennessee	43rd	19%	32%	23%	27%	16
Carter	48/95	23%	29%	31%	34%	20
Cocke	88/95	27%	31%	21%	41%	21
Greene	59/95	21%	32%	29%	30%	22
Hamblen	54/95	26%	30%	23%	29%	27
Hancock	93/95	29%	30%	40%	45%	42
Hawkins	64/95	26%	35%	26%	31%	26
Johnson	44/95	26%	31%	28%	38%	11
Sullivan	36/95	22%	33%	26%	28%	17
Unicoi	68/95	26%	30%	23%	29%	24
Washington	19/95	19%	31%	24%	24%	17
Virginia	21st	14%	28%	18%	16%	9
Buchanan	132/133	29%	29%	30%	33%	37
Dickenson	130/133	31%	29%	32%	28%	53
Grayson	74/133	20%	32%	22%	29%	Not Reported
Lee	116/133	29%	29%	25%	39%	14
Russell	122/133	29%	35%	25%	26%	32
Scott	114/133	23%	34%	28%	27%	14
Smyth	123/133	29%	31%	22%	26%	15
Tazewell	133/133	29%	30%	21%	23%	37
Washington	82/133	19%	32%	24%	21%	13
Wise	129/133	24%	32%	33%	28%	38
Wythe	85/133	27%	30%	24%	22%	18

University of Wisconsin Population Health Institute. County Health Rankings 2015. Accessible at www.countyhealthrankings.org

The State of Tennessee has identified the "Big Three Plus One" health issues (physical inactivity, obesity, tobacco abuse and substance abuse) as major health challenges for the state. These health issues are particularly significant challenges for the Geographic Service Area and are associated with other health challenges and conditions.

Physical Inactivity & Obesity

Obesity and physical inactivity are mutually reinforcing public health concerns. Tennessee's state level obesity rate exceeds the national average. While most of the Tennessee counties in the Geographic Service Area have obesity rates lower than the state average, Hawkins and Sullivan Counties are exceptions at 35% and 33% respectively. All of the Tennessee counties in the Geographic Service Area exceed the state average for physical inactivity (30%). Most notably, Unicoi County has a physical inactivity rate of 37.0% and Hancock County has a physical inactivity rate of 39.4%. Measures for Virginia counties in the service area reflect challenges as well.

Tobacco Abuse

The "2015 Drive Your County to the Top Ten" report[28] published by the Tennessee Department of Health Division of Policy, Planning, and Assessment State Department of Health demonstrates that all of the Tennessee counties in the Geographic Service Area exceed the national average for smoking, and seven of the ten Tennessee counties exceed the state average for smoking. In particular, Hancock County and Carter County are at the high end of the range with smoking rates that exceed 30%.

Substance Abuse

Substance abuse is a key priority of the Tennessee Department of Health and a significant concern in this region. Of the ten Tennessee counties in the Geographic Service Area, nine exceed the state average in the number of deaths due to drug poisoning per 100,000 population. Of particular note is Hancock County, which has the highest drug poisoning mortality rate in the state. Addressing substance abuse is one of the highest priorities of the New Health System, with efforts to address the specific needs of this population as well as improve access to, and coordination of care at, health care facilities for substance abuse patients.

Table 8.2 reports key statistics on the population in the counties in the Geographic Service Area for the "Big Three Plus One" health issues, including metrics for physical inactivity, obesity, tobacco use, and substance abuse. Red shading indicates that the County scores worse than the state average for that particular metric.

[28] "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015; *available at*: https://www.tn.gov/health/topic/specialreports.

Table 8.2 - County-Level Data for Physical Inactivity, Obesity, Tobacco Abuse, and Substance Abuse in the Geographic Service Area

	Physical Inactivity Score[29]	Obesity[30]	Tobacco Abuse[31]	Substance Abuse Score[32]
Tennessee Average	30%	32%	23%	16
Carter County	32%	29%	31%	20
Cocke County	36%	31%	21%	21
Greene County	36%	32%	29%	22
Hamblen County	33%	30%	23%	27
Hancock County	39%	30%	40%	42
Hawkins County	35%	35%	26%	26
Johnson County	34%	31%	28%	11
Sullivan County	35%	33%	26%	17
Unicoi County	37%	30%	23%	24
Washington County	30%	31%	24%	17
Virginia Average	22%	28%	18%	9
Buchanan	28%	29%	30%	37
Dickenson	32%	29%	32%	53
Grayson	30%	32%	22%	Not Reported
Lee	27%	29%	25%	14
Russell	36%	35%	25%	32
Scott	35%	34%	28%	14
Smyth	23%	31%	22%	15
Tazewell	31%	30%	21%	37
Washington	30%	32%	24%	13
Wise	38%	32%	33%	38
Wythe	27%	30%	24%	18

The Parties share the State's concern about these four significant health issues and are aware of the acute challenges present in this region. The Parties intend for these

[29] Physical Inactivity: Percentage of adults aged 20 and over reporting no leisure-time physical activity. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.

[30] Adult Obesity: Percentage of adults that report a BMI of 30 or more. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.

[31] Adult Smoking: Percentage of adults who are current smokers. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.

[32] Substance Abuse: Drug Poisoning Mortality Rate per 100,000 Population Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.

four issues to be key areas of focus within the scope of the current Community Health Work Groups, as well as included in the Advisory Groups that will work to define the ongoing health index for the Cooperative Agreement.

These variables impose increased costs on employers, the government and society in general because the cost to manage the health of these populations is much higher and often reactive and acute, rather than proactive. Poor health leads to higher inpatient utilization. A major component of the change the New Health System seeks to impact is to improve the determinants of poor health that lead to unnecessary inpatient utilization, better manage the "super-utilization" of health resources and, through collaboration with payers, align the incentives to ensure appropriate utilization.

The region is materially affected by the federal policy of paying local hospitals based on one of the lowest Medicare Wage Indices in the nation. This leads to substantially lower reimbursement than peer hospitals in other states and in Tennessee for the exact same services. The low rates, combined with the expensive, unnecessary and inefficiently allocated duplicative health care resources currently existing in our region, make it difficult for the two systems to independently invest the resources required to meaningfully influence the variables that contribute to poor health. These factors confine the region's health systems to the model that has led to higher cost in the first place.

Furthermore, there is projected continued downward pressure on reimbursement by government payers, as costs for labor and supplies, many of which are unnecessarily duplicative, continue to grow. By better coordinating the two systems, eliminating unnecessary duplicative cost, and creating a better focus on the drivers of poor health, the New Health System will make a material positive impact on the region's health care.

Thus, 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 health outcomes in the region. The specific initiatives of the Cooperative Agreement are summarized below, followed by a description of the Parties' specific commitments to achieve these goals and the resulting benefits:

- A fully integrated and interactive Common Clinical IT Platform will be implemented to enable ready access to patient records by physicians from any location in the New Health System. Implementation of this Common Clinical IT Platform requires sharing of highly proprietary information and commitment of significant resources by both systems, which would not be accomplished in the absence of a merger.

- The New Health System will participate meaningfully in an existing or new health information exchange to promote coordination among

community providers, including those providers not part of the New Health System. The regional health information exchange will facilitate the sharing of information, including highly proprietary information to the extent feasible, and a commitment of significant resources, which would not be accomplished in the absence of a merger.

- Management and clinical practice procedures and policies will be standardized to promote efficiency and higher standards of care on a consistent basis throughout the New Health System through a system-wide Clinical Council. It would not be possible for the two competing systems to standardize procedures and policies for best practices absent the merger. Such standardization to improve health care requires sharing of proprietary information and significant contribution of resources by both parties, as discussed below.

    - Best practices will be used to develop standardized clinical protocols for care ("Clinical Pathways") to reduce clinical variation and overlap, shorten length of stay, reduce costs, and improve patient outcomes. The Cooperative Agreement will allow sharing of the clinical and financial information needed to integrate this process.

    - The integration and coordination of clinical services made possible by the merger will free up resources that can be directed to develop new health care services and to enhance existing services, discussed more fully below. Clearly, the resources needed to achieve these goals would not be available in the absence of the merger.

    - 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.

    - The New Health System's services and staff will be optimally located to improve productivity and ensure access.

    - Clinical programs will be integrated to establish centers of excellence that coordinate and optimize care throughout the New Health System. Our three tertiary hub hospitals will serve not only as training sites for new physicians and allied health professionals, but will also utilize effective technology and cutting edge treatment in concert with translational research.

To enhance the quality of health care services provided in the region to achieve the above benefits, the Parties are willing to commit to the following:

i. Migrate to a Common Clinical IT Platform

(a) The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.

(b) The Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care.

(c) The Common Clinical IT Platform will also facilitate the increased adoption of best practices and evidence based medicine implemented by the New Health System.

(d) The New Health System intends to use the Common Clinical IT Platform to provide immediate system-wide alerts and new protocols to improve quality of care.

(e) The New Health System expects the Common Clinical IT Platform to be utilized in ways that will help reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

ii. Support Regional Efforts For Establishment of a Region-Wide Health Information Exchange

(a) The New Health System will support development and operation of a region-wide health information exchange (the "Health Information Exchange") that will include independent providers, medical groups and facilities.

(b) The Health Information Exchange will encourage and support patient and provider connectivity to the New Health System's integrated information system.

(c) The New Health System will coordinate with third parties to establish the technology platform vendor for the Health Information Exchange and to provide key data security and relevant protocols to all users.

(d) The New Health System will utilize the Health Information Exchange to further facilitate better patient care and coordination of care, and to decrease the unnecessary duplication of health care services.

iii. Establish System-Wide Clinical Council

(a) The New Health System will establish a system-wide, physician-led clinical council (the "Clinical Council").

(b) The Clinical Council will be composed of independent physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates. The Clinical Council will include representatives of management but the majority will be composed of physicians.

(c) The Clinical Council may be supported by other clinicians, subject matter experts, and senior management.

(d) The Chair of the Clinical Council will be a physician member of the active medical staff(s) of one or more New Health System hospitals. The Chair will serve on the Quality, Service and Safety Committee of the Board of Directors of the New Health System and will provide ongoing reports on the activities of the Clinical Council through the Quality, Service and Safety Committee of the Board.

(e) The Clinical Council will be responsible for establishing a common standard of care, credentialing standards, consistent multidisciplinary peer review where appropriate and quality performance standards and best practices requirements for the New Health System.

(f) The Clinical Council will also provide input on issues related to clinical integration, and shall support the goals established by the Board of Directors of the New Health System.

(g) The Clinical Council will report to the Chief Medical Officer of the New Health System.

iv. Quality Reporting

(a) The Parties affirm the need for complete transparency on quality measures with respect to the performance of the New Health System. The Parties will report on a common and comprehensive set of measures and protocols that will be part of the integrated delivery of care across the entire New Health System, as well as track and monitor opportunities to improve health and access to care at the right place and right time for consumers. Timely information will be available to the public, which will impact choice and further incentivize the provision of high quality of care. Increased transparency will provide consumers with information for their use to make better health care decisions.

(b) The New Health System will commit to publicly reporting on its website the New Health System's CMS core measures[33] for each

[33] CMS Hospital Compare metrics are publicly *available at*: https://data.medicare.gov/data/hospital-compare. As

facility within thirty days of reporting the data to CMS. The New Health System will also provide benchmarking data against the most recently available CMS data so the public can evaluate and monitor how the New Health System facilities compare against hospitals across the state and nation in a manner that is more "real time" than currently available. Publicly reported CMS Hospital Compare measures, by category, along with the number of measures in each respective category are presented in **Table 8.3** below. These demonstrate the breadth of commitment by the Parties to provide comprehensive and timely information for benchmarking and for consumers.

indicated in **Table 8.1** herein, there are seventeen categories of measures and each category contains a set of measures. For example, Readmissions & Deaths is one of the 17 Hospital Compare measure categories. This category contains fourteen individual measures including, for example, AMI 30-day mortality rate, Pneumonia 30-day mortality rate, and the Rate of readmission after discharge (hospital-wide).

Table 8.3 - CMS Hospital Compare Measures

Measure Category	Number of Measures
Healthcare-associated infections(HAI)	6
Inpatient Psychiatric Facility Quality Reporting(IPFQR)Program	6
Outpatient Imaging Efficiency	6
Payment & value of care	4
Readmissions & deaths	14
Surgical Complications	7
Survey of patients' experiences(HCAHPS)	11
Timely and effective care- Blood Clot Prevention and Treatment	6
Timely and effective care- Children's Asthma	3
Timely and effective care- Emergency Department	7
Timely and effective care- Heart Attack or Chest Pain	9
Timely and effective care- Heart Failure	3
Timely and effective care- Pneumonia	1
Timely and effective care- Pregnancy and Delivery Care	1
Timely and effective care- Preventive Care	2
Timely and effective care- Stroke Care	8
Timely and effective care- Surgical Care Improvement Project	9

- The New Health System's results will be available on its website and reported several months earlier than CMS customarily makes the information available to the public. Currently, there is an approximate six-month lag between when core measures are reported to CMS and when CMS posts the information for the public. The New Health System intends to empower patient decision making by reporting core measures in advance of the federal agency reporting.

- CMS periodically changes the core measures it requires hospitals to report. To ensure patients have information on the latest CMS core measures, the New Health System will commit to include all current CMS core measures in its public reporting on the website, rather than a pre-defined set of measures chosen by the Parties.[34]

[34] The New Health System will commit to using the same standards of reporting as CMS and reserves the right to not report those core measures that would not be reported by CMS (e.g. too few patients for the metric to be

(c) The New Health System will commit to publicly reporting on its website measures of patient satisfaction for each facility within thirty days of reporting the data to CMS via the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") reporting. The New Health System will also provide benchmarking data against the most recently available CMS patient satisfaction scores so the public has access to how the New Health System facilities compare against hospitals across the state.

- The New Health System's results will be available on its website and reported several months earlier than CMS customarily makes the information available to the public.

(d) The New Health System will commit to publicly reporting on its website specific high priority measures for each facility annually, with relevant benchmarks. The high priority measures are set by CMS[35] and the Joint Commission and have in the past included:

- Central Line-Associated Bloodstream Infections,
- Catheter-Associated Urinary Tract Infections, and
- Ventilator Associated Pneumonia Infection Rates.

(e) The New Health System will commit to publicly reporting on its website surgical site infection rates for each facility annually.

(f) The New Health System will commit to publicly reporting on its website the ten most frequent surgical procedures performed (by number of cases) at each Ambulatory Surgery Center in the system annually. Studies have shown that facilities performing high volumes of a procedure may have better outcomes than those performing low volumes.[36] The New Health System intends to be transparent about the volume of procedures it performs and the outcomes related to those procedures.

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statistically significant, protected health information concerns with the metric being reported, etc.).

[35] The New Health System will commit to using the same standards of reporting as CMS and reserves the right to not report those high priority measures that would not be reported by CMS (e.g. too few patients for the metric to be statistically significant, etc.).

[36] *High-volume trauma centers have better outcomes treating traumatic brain injury,* Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, Journal of Trauma and *see* Acute Care Surgery, January 2013, *available at:* http://www.ncbi.nlm.nih.gov/pubmed/23271089 *Relationship between trauma center volume and outcomes*, Avery B. Nathens, MD, PhD, MPH; Gregory J. Jurkovich, MD; Ronald V. Maier, MD; David C. Grossman, MD, MPH; Ellen J. MacKenzie, PhD; Maria Moore, MPH; Frederick P. Rivara, MD, MPH, Journal of American Medical Association, March 2001, *available at:* http://jama.jamanetwork.com/article.aspx?articleid=193615.

(g) The New Health System will commit to improved transparency and reporting on high priority measures for quality and cost by reporting annually on its website the following information by facility, aggregated for the facility across the DRGs that comprise eighty percent (80%) of the discharges from the New Health System facilities:[37]

- Severity adjusted cost/case;
- Length of stay;
- Mortality rate; and
- Thirty-day readmission rate.

(h) The New Health System will also commit to report these quality measures on its website for the top ten DRGs aggregated across the system annually. By reporting on these quality measures specific to each of the top 10 DRGs for the system as a whole, the New Health System is committing to a new level of transparency and accountability for care in the service lines that account for greatest usage by the population. The top 20 DRGs by system for 2014 are listed in **Table 8.4** below:

[37] Cost and utilization metrics could include broad measures such as: total medical cost per member per year, inpatient admissions per 1000, average length of stay, percentage readmissions within 30 days, ER visits per 1000, Evaluation and Management per 1000, Scripts per 1000. More detailed expenditure and utilization statistics could be presented for inpatient by treatment type (Medical, Surgical, Psychiatric/Substance Abuse, Maternity/Newborn, Non Acute & LTC), outpatient by treatment type (Surgery, ER, Home Health, DME, Lab, Radiation, Pharmacy, Other) and Providers (PCP, Specialist, Transportation, DME & Supplies, Spec Drugs & Injections, and Other). The report could include costs for the top 10 DRGs by volume, evaluation and management visits by group, Rx Utilization, top 20 Clinical Conditions by Medical Cost, and top 10 patients (identified by clinical condition) by cost.

Table 8.4 - Top DRGs by Health Systems, 2014

Top 20 Discharge DRGs for Combined MSHA and Wellmont, 2014			
No.	DRG	DRG Description	Total Discharges
1	885	PSYCHOSES	5,320
2	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	3,627
3	775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	3,283
4	470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2,820
5	189	PULMONARY EDEMA & RESPIRATORY FAILURE	1,965
6	392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	1,950
7	603	CELLULITIS W/O MCC	1,716
8	194	SIMPLE PNEUMONIA & PLEURISY W CC	1,651
9	193	SIMPLE PNEUMONIA & PLEURISY W MCC	1,619
10	872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1,535
11	690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	1,423
12	794	NEONATE W OTHER SIGNIFICANT PROBLEMS	1,413
13	766	CESAREAN SECTION W/O CC/MCC	1,402
14	683	RENAL FAILURE W CC	1,342
15	291	HEART FAILURE & SHOCK W MCC	1,174
16	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1,147
17	292	HEART FAILURE & SHOCK W CC	1,063
18	247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	1,026
19	378	G.I. HEMORRHAGE W CC	966
20	765	CESAREAN SECTION W CC/MCC	948
Note: The table excludes normal newborns (DRG 795).			
Source: Combined all-payor IP discharge data from Virginia State & Tennessee State, calendar year 2014			

(i) The New Health System will select a third-party vendor and provide the data for the vendor to analyze the severity adjusted measures and post them to the New Health System's website.

B. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities.

Health care services offered by rural hospitals in the United States are at increasing risk of closure. According to the University of North Carolina Sheps Center, sixty-six rural hospitals have closed since 2010, including six in Tennessee and one in Virginia.[38] Wellmont and Mountain States each make substantial investments in order to maintain access to health care services in their rural communities. As presented in **Tables 5.2** and **5.3**, many of the Parties' rural hospitals have an average daily census of twenty patients or less.

[38] *See 66 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, *available at*: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (accessed January 25, 2016).

Because of decreasing reimbursements and the other challenges mentioned earlier, it will be increasingly difficult to continue to sustain these facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement.

Currently, most rural hospitals operated by Wellmont and Mountain States operate with negative or very low operating margins, representing challenges to the capitalization and, ultimately, the survival of these hospitals. Last year alone, Mountain States and Wellmont collectively invested more than $19.5 million to ensure that inpatient services would remain available at the following rural hospitals: Smyth County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Johnson County Community Hospital, Dickenson Community Hospital, Norton Community Hospital, Johnston Memorial Hospital, Hawkins County Memorial Hospital, Hancock County Hospital, Lonesome Pine Hospital, and Mountain View Regional Medical Center. In the current resource-constrained, status-quo environment, these hospitals face an uncertain future with respect to their viability. The existing threat to these hospitals is substantial, which affects not only access to care, but also the economic vitality of these communities.

The proposed Cooperative Agreement is a thoughtful mechanism for ensuring that the efficiencies from a merger that is actively supervised will be used to ensure sustained access to care for these communities. Without such a Cooperative Agreement, there is no comparable assurance. Specifically, the Parties commit to the following:

COMMITMENTS

- All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.

COMMITMENTS

- The New Health System will maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available in close proximity to where the population lives.

- The New Health System will commit to the 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. The Parties expect the combined system to facilitate this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding.

C. Gains in the cost containment and cost efficiency of services provided by the hospitals involved.

Federal and state regulatory agencies impose significant cost constraints on all hospital providers. Medicare and Medicaid payment rates are non-negotiable and are often applied as benchmarks by other payers. Medicare costs are regulated through the Medicare Wage Index. In Northeast Tennessee and Southwest Virginia, payment rates remain lower because the local Medicare Wage Index is one of the lowest in the nation. With a payer mix for the regional health systems that is approximately 70% Medicare, Medicaid, and Medicare managed care, this wage index serves as a fundamental regulator of health care costs.[39]

The proposed Cooperative Agreement complements federal and state efforts to contain costs and promote cost efficiency in several ways.

Through the Cooperative Agreement, the two health systems will be able to avoid unnecessary duplication of services. By integrating their efforts in key service areas, the Parties will avoid duplicative costs and will be able to operate these facilities and services more efficiently, with better quality and with enhanced patient outcomes. One example of duplicative services the New Health System can potentially consolidate is the area's two Level I Trauma Centers, which are expensive to maintain and redundant in a region with low

[39] See **Exhibit 5.1C** for a breakdown of payers in the Geographic Service Area.

population density. No other region in Tennessee operates two Level I centers. Consolidation of these programs into a single facility is projected to result in cost savings. Significantly, studies have shown that higher-volume trauma centers result in better patient outcomes.[40] Thus, a consolidation would likely result in lower cost and improved outcomes. Other cost-saving and efficiency opportunities include consolidation of specialty pediatric services, repurposing acute care beds and consolidation of certain co-located facilities.

The New Health System will also achieve greater cost efficiencies through various organizational and administrative efficiencies as described in **Section 11.i**. Such efficiencies include, among other things, non-labor efficiencies, labor efficiencies, clinical efficiencies, and the opportunity to consolidate technology resources on a Common Clinical IT Platform as described in **Section 8.A.i**.

Specifically, the Parties commit that the New Health System will achieve at least $95 million in annual efficiencies by the end of the fifth year of operation. The potential savings identified here are limited to the estimated dollar savings from the realignment of resources and certain clinical efficiencies, but do not include the potentially significant benefits that the Parties expect to achieve through improved access, quality, and care in the best locations that will directly benefit these communities. Importantly, that work must be done only after significant study and assessment along with input from key stakeholders and physicians, guided by the Alignment Policy set forth in this document. The work must be orderly, methodical, and well communicated. While the efficiency numbers set forth above were established and validated by independent outside experts, only certain sample initiatives have been set forth in this document.

D. Improvements in the utilization of hospital resources and equipment.

In addition to reduced costs through improved efficiency and avoidance of waste and duplication, the New Health System will reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers. Currently, 126 patients for every 1,000 people in Tennessee[41] are admitted to the hospital annually, compared to a national average of 106 admissions/1,000 population. The Parties believe the creation of

[40] *See High-volume trauma centers have better outcomes treating traumatic brain injury,* Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, Journal of Trauma and *see* Acute Care Surgery, January 2013, *available at:* http://www.ncbi.nlm.nih.gov/pubmed/23271089. *Relationship between trauma center volume and outcomes*, Avery B. Nathens, MD, PhD, MPH; Gregory J. Jurkovich, MD; Ronald V. Maier, MD; David C. Grossman, MD, MPH; Ellen J. MacKenzie, PhD; Maria Moore, MPH; Frederick P. Rivara, MD, MPH, Journal of American Medical Association, March 2001, *available at:* http://jama.jamanetwork.com/article.aspx?articleid=193615.

[41] This figure is reported by the Kaiser Family Foundation for the state of Tennessee for 2013. Source: Kaiser Family Foundation's Hospital Admissions per 1,000 Population, *available at*: http://kff.org/other/state-indicator/admissions-by-ownership/.

a regionally integrated health system with a comprehensive regional health information exchange will help reduce unnecessary utilization.

The proposed merger will result in a Common Clinical IT Platform for electronic medical records among the combined nineteen hospitals, employed physicians and related services, and will facilitate a community health information exchange between participating community providers in the region, as described above. This combination will help ensure that providers have the information they need to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. Patient information will be more portable, removing barriers to patient choice and improving patients' access to their own health information. A more fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services resulting in a better patient experience and more effective and efficient care.

To reduce the pace of health care cost growth for 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 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.

* 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.

COMMITMENTS

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

- 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.

- The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.

- The New Health System will participate meaningfully in a health information exchange open to community providers.

- The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.

* 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.

All of these efforts would not be undertaken in the absence of the merger due to a variety of factors, including the need to share proprietary information and the significant commitment of resources to be made by the Parties as part of the merger. Moreover, commitments relating to pricing, consolidation of services, standardization of practices, and procedures, would raise significant antitrust concerns if undertaken together by two independent hospital systems. 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 benefits and would not come close to achieving the same level of efficiencies, cost-savings and quality enhancement opportunities as the New Health System. It would also not be subject to rigorous rate regulation by state authorities, even though there are concerns that out-of-market acquirers may raise the acquired hospital's prices.

In the event of repeal or material modification of the Tennessee Certificate of Need law and/or the Virginia Certificate of Public Need law, the Parties – solely with respect to outpatient, physician, and additional non-hospital healthcare services (collectively, the "non-inpatient services") – reserve the right for the New Health System to enter exclusive network and most-favored nation agreements with insurers, and to engage in any other competitive practices that comply with the antitrust laws regarding the non-inpatient services, notwithstanding the commitments stated in the Application.

E. Avoidance of duplication of Hospital resources.

A major factor in the accumulation of nearly $1.5 billion of debt, and the redundant costs borne by the market, has been the duplication of services and programming by Wellmont and Mountain States as separate systems. Combining the region's two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services moving forward. These efforts will provide savings that may be invested in higher-value activities in the region to help expand currently absent but necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. These new levels of development and job creation will not be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources. While any alternative model to this proposal would likely lead to significant job displacement in the region, the proposed merger would mitigate this impact through investment in new programs as outlined in this application.

The Parties also anticipate cost savings through capital cost avoidance. This includes avoiding duplication in select clinical areas, as well as foregoing planned duplicative strategic investments for initiatives that would no longer be warranted as a combined entity.

F. Demonstration of Population health improvement of the region served according to criteria set forth in the Cooperative Agreement and approved by the Department.

Wellmont and Mountain States are committed to creating a New Health System designed to improve community health. To accomplish this, the New Health System will commit to pursuing health improvements aligned with goals contained in the current Tennessee State Health Plan, the Virginia Health Innovation Plan (including the Lieutenant Governor's Quality, Payment Reform, and HIT Roundtable and Virginia's Plan for Well Being) and with regional collaborative health improvement goals such as those set forth in Healthier Tennessee and the Blueprint for Health Improvement and Health-Enabled Prosperity.

All of these efforts recognize that ultimately, individual and community health and well-being are not primarily driven by health care services, but instead by income, education, family and community support, personal choices, genetics and the environment. As the 2014 Tennessee Health Plan states, "We know that health care alone cannot make major improvements in population health. To make significant improvements, we need to understand what 'being healthy' and 'staying healthy' mean, and how to encourage our entire society to value health. In other words, we need to build a culture of health."

The New Health System is committed to create 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. The New Health System would commence the population health improvement process with the preparation of a comprehensive community health improvement plan, identifying the key 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 population health improvement funding may be committed to the following initiatives, as well as others based upon the 10-year action plan for the region.

i. ***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.

ii. ***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.

iii. ***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.

iv. ***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 New Health System will also provide financial support to develop and sustain an Accountable Care Community effort across state lines for the region that will help address these and other issues identified by the community health improvement plan. As described in the section below, some of this work is already underway. Wellmont and Mountain States have worked with the College of Public Health at ETSU to organize four Community Health Work Groups to focus on the root causes of poor health in the region and identify actionable interventions for a generational shift in health trends. It is expected that the membership of these Community Health Work Groups could form the initial core of the Accountable Care Community structure.

G. The extent to which medically underserved population have access to, and are projected to utilize, the proposed services.

In cooperation with the College of Public Health at ETSU, the Parties have launched the region's most substantial community health improvement assessment effort to date. 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. As described above, the Parties have jointly sponsored and funded these four Work Groups only as part of the Parties' goal to improve health care services through the Cooperative Agreement.

The four Community Health Work Groups and the eight community leaders who are serving as chairpersons are set forth below:

- Mental Health & Addiction: Dr. Teresa Kidd, president and CEO of Frontier Health, and Eric Greene, senior vice president of Virginia services for Frontier Health;
- Healthy Children & Families: Dr. David Wood, chair of the department of pediatrics at ETSU, and Travis Staton, CEO of United Way of Southwest Virginia;
- Population Health & Healthy Communities: Dr. Randy Wykoff, dean of ETSU's College of Public Health, and Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City;
- Research & Academics: Dr. Wilsie Bishop, vice president for health affairs and chief operating officer of ETSU, and Jake Schrum, president of Emory & Henry College.

These Community Health Work Groups are jointly funded by the Parties. The charters and membership lists of each Work Group are attached as **Exhibit 8.2A and Exhibit 8.2B**[42].

The Community Health Work Groups met during the Fall of 2015 in public meetings throughout Northeast Tennessee and Southwest Virginia to seek community input. The meetings were led by subject matter experts and included business and community leaders from throughout the region who represent a broad variety of experience and perspectives. The meetings were also staffed by members of Mountain States and Wellmont along with master's and doctoral level students from ETSU. The extensive schedule of public meetings already conducted by these four Work Groups is attached as **Exhibit 8.3**.

ETSU has been engaged jointly by the Parties to analyze the community input received at these Community Health Work Group meetings and to develop a 10-year plan for addressing these community health opportunities for improvement.

Specifically, the 10-year plan will utilize the input received in the Community Health Work Group sessions in the following ways:

- Mental Health & Addiction Work Group: The Mental Health and Addiction Work Group is charged with evaluating the inventory of mental health and addiction services for adults and children in the

[42] The membership list reflects all members of each Work Group as of January 25, 2016.

area. An important objective is to provide data and analysis that will assist the New Health System in developing an optimal structure to combat addiction and substance abuse, reduce the number of newborns born into addiction, and to reduce dependency on drugs and alcohol through improved access and support. The New Health System will use findings from this group to partner with the medical and social service community to combat addiction and support the next generation to achieve its potential.

- Healthy Children & Families: The Healthy Children and Families Work Group is charged with exploring the opportunities and necessary actions for structuring a comprehensive regional approach to child well-being in Northeast Tennessee and Southwest Virginia. The work group will produce a report that identifies the most prominent physical, behavioral, and social health problems affecting children in the region and explores their causes, taking into account the social and family support necessary to equip children to make the strongest possible start in their journey to adulthood.

- Population Health & Healthy Communities: The Population Health and Healthy Communities Work Group is charged with exploring opportunities and necessary actions to improve the overall health and well-being of Northeast Tennessee and Southwest Virginia by aligning and mobilizing public and private sector resources - schools, businesses, civic and faith groups; health care providers; government - around a core set of community health improvement goals in the areas of both health care delivery and social determinants of health. The New Health System will utilize the findings from this group to identify health care delivery goals that could be improved, including, but not limited to: increased vaccinations and screenings, improved integration of primary care, dental and mental health services, improved access to preventive and treatment services for persons with addictive disorders, and reductions in hospital acquired conditions.

- Research & Academics: The Research and Academics Work Group is charged with exploring the opportunity to improve health and economic growth in Northeast Tennessee and Southwest Virginia by enhancing professional recruitment and research-based funding under a new research and academics partnering strategy between the New Health System and regional academic institutions. The findings from this Work Group will be used by the New Health System and its research partners to interface with an effort to create an accountable care community – in particular, analyze what

infrastructure is needed to use the benefit of research to support the initiatives and priorities identified in the accountable care community model.

In addition to utilizing the Community Health Work Groups to identify the services most needed by the medically underserved population, 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. The charity care policy and related policies for Mountain States is attached as **Exhibit 8.4**. The charity care policy and related policies for Wellmont is attached as **Exhibit 8.5**. 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 and consistent with the IRS's final 501(r) rule.

H. Any other benefits that may be identified.

Behavioral Health and Substance Abuse. Behavioral health and substance abuse issues are a major health factor in the geographic area served by the Parties, and there are currently significant gaps in the continuum of care related to these issues. As part of the public benefit associated with the merger, the New Health System is prepared to make major investments in programs and partnerships that will help to address these issues. The societal cost associated with mental illness and substance abuse is extensive, and, given that the single largest diagnosis related to regional inpatient admissions is psychoses, these issues merit priority attention.

According to the American Hospital Association, one in four Americans experiences a behavioral health issue or substance abuse disorder each year, with the majority of those also experiencing physical health conditions or chronic diseases that complicate care needs.[43] Thus, these patients typically have higher levels of health care utilization. It has been estimated that medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder conditions can be 2-3 times as high as for those who do not have a mental health/substance abuse disorder.[44]

Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thereby contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to support the development of effective behavioral health and substance abuse

[43] American Hospital Association. (2012, January). Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Cost and Outcomes. Trendwatch. Chicago, IL: American Hospital Association. *Available at*: http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf.

[44] Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman, Inc. April 2014. *Available at:* http://integrationacademy.ahrq.gov/node/5950.

resources to provide high-quality, well-coordinated, and more proactive care. The Parties recognize that important relationships must be developed across a continuum of community-based resources, primary care, intensive outpatient care, and inpatient care. In fact, effective systems of care and provider resources in the outpatient environment and the community go a long way in reducing the need for acute hospitalization or emergency department use. Though the New Health System will work to ensure appropriate inpatient resources exist, the main focus of development in this area will be outpatient systems of care, coordinated systems of care in the community, sufficient provider and specialized counseling resources, and residential recovery services.

The New Health System will work within the existing framework of resources and partnerships across the region to identify needs associated with this area as well as gaps in service offerings. In fact, this is a major focus of the assessment being performed with ETSU through one of the priority Community Health Work Groups. The Parties expect to identify a more integrated care model similar to what is outlined by the Agency for Healthcare Research and Quality ("AHRQ") for the region through the efforts of the Community Health Work Groups. That model includes primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care addressing mental health, substance abuse conditions, health behaviors, life stressors and crisis, stress-related physical symptoms, and ineffective patterns of health care utilization.

The work of AHRQ and other evidence-based best practices will be used as a guide to support the development of regional services in a model that is coordinated, co-located, and integrated to overcome the disparate and disconnected manner in which individuals are currently treated. The New Health System will have tremendous opportunities to support a network of care resources across the region in partnership with agencies such as Frontier Health, Highlands Community Services, the regional rural health centers and Federally Qualified Health Centers, faith-based organizations, and health departments. Together with these partnership networks, the care resources associated with the New Health System, including primary care networks, emergency department networks, and inpatient behavioral health, will position the system to positively impact the development of this continuum of resources in an unprecedented way.

Common Clinical IT Platform. The Cooperative Agreement will allow the New Health System to leverage its integrated technology systems, combined with data from within the community to better coordinate population health efforts. By creating a "single team" approach, the combined system will promote collaboration across inpatient and outpatient care environments, engage

patients, and manage health care data to promote healthier living and manage chronic care conditions. Specifically, the Parties are willing to commit as follows:

COMMITMENTS

- The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.
- The New Health System will commit to participate meaningfully in a health information exchange open to community providers.

Quality and Availability. The quality and availability of health care services will improve under the proposed Cooperative Agreement. Wellmont and Mountain States have been developing quality measurement systems independently of one another. Working together, the Parties believe they will be able to improve how quality is measured not only at their respective hospitals, but also throughout the region. Specifically, the Parties commit to the following:

COMMITMENTS

- 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.

Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Parties intend to maintain community outreach programs, such as programs for the elderly and the very young, and be able to better afford to attract and retain top quality specialists in areas either not now offered or at risk of out-migration from either one or both hospital systems. For example, the proposed merger will produce savings which will be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise could not be supported in a region of this size, geography and population density.

The Cooperative Agreement will allow the hospitals the opportunity to continue to offer programs and services that are now unprofitable and otherwise may have to be reduced or cancelled due to lack of funding. Specifically, the New Health System will commit to spending at least $140 million over ten years pursuing specialty services including those outlined in the commitments below.

These initiatives would not be sustainable in the region without the financial support created by the merger.

COMMITMENTS

- The New Health System will create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
- The New Health System will develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements.
- The New Health System will ensure recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment.
- The New Health System will develop 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 in close proximity to patients' homes.

The Parties do not foresee any adverse impacts on population health, quality, access, availability or cost of health care to patients and/or payers as a result of the Cooperative Agreement. The projects and commitments identified in this Application will clearly improve health care in the region.

The Parties and the State share a common interest in ensuring that the financial commitments set forth in this Application are maintained to achieve the longer-term population health goals for the region served by the New Health System. In the event of a natural disaster or other extraordinary circumstance beyond the New Health System's control that would materially risk the financial or operational stability of the New Health System, the Parties may file an amended schedule and investment plan for the commitments to the State for approval. Such amended schedule or contingency plan will specify the financial or operational issues that warrant an amended schedule or contingency plan, and detail how the amended plan or contingency plan is consistent with the intended goals and priorities of the original commitments.

9. STATEMENT ON PROJECTED LEVELS OF COST, ACCESS TO HEALTH CARE, OR QUALITY OF HEALTH CARE

REQUEST: Provide a statement of whether the projected levels of cost, access to health care or quality of health care could be achieved in the existing market without the granting of a COPA; and, for each of the above, an explanation of why or why not.

RESPONSE: The significant ongoing duplication of services and costs cannot be avoided without a consolidation. 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 as further described in **Section 11.i**.

Further, the extensive commitments described herein to improve access to health care and quality of health care could not be achieved without the combination and would not be effectively enforced absent an active state supervision program mandated by Virginia and Tennessee law. A merger by Wellmont or Mountain States with a different entity would fall well short of the New Health System's potential for realizing the major integrative efficiencies described herein, which, in turn, will help fund and sustain the Parties' unprecedented and enforceable commitments to health care cost control and quality improvement in the Geographic Service Area. The proposed consolidation of Wellmont and Mountain States, without a COPA, would likely implicate state and federal antitrust laws. As a result, the potential efficiencies and benefits identified in this Application could not be achieved in the existing market without the granting of a COPA.

10. REPORT USED FOR PUBLIC INFORMATION

REQUEST: Provide a report used for public information and education that is documented to have been disseminated prior to submission of the Application and submitted as part of the Application. The report must include the following:

(i) A description of the proposed geographic service area, services and facilities to be included in the Cooperative Agreement;

(ii) A description of how health services will change if the Application is accepted;

(iii) A description of improvements in patient access to health care including prevention services for all categories of payers and advantages patients will experience across the entire service area regarding costs, availability or accessibility upon initiation of the Cooperative Agreement and/or findings from studies conducted by hospitals and other external entities, including health economists, clinical services and population health experts, that describe how proposed Cooperative Agreement plans are effective with respect to resource allocation implications; efficient with respect to fostering cost containment, including, but not limited to, eliminating duplicate services and future plans; and equitable with respect to maintaining quality and competition in health services within the service area, assuring patient access to and choice of insurers and providers within the health care system;

(iv) Findings from service area assessments that describe major health issues and trends, specific population health disparities and comparisons to state and other similar regional areas proposed to be addressed;

(v) Impact on the health professions workforce including long-term employment and wage levels and recruitment and retention of health professionals; and

(vi) A record of community stakeholder and consumer views of the proposed Cooperative Agreement collected through a public participatory process including meetings and correspondence in which this report or its components were used.

RESPONSE: The Parties prepared the Pre-Submission Report attached as **Exhibit 10.1** to educate the public on the proposed merger and seek additional community input. The Pre-Submission Report was posted on the Parties' website on January 7, 2016 and the Parties publicized the release of the report through various news outlets. The community has been invited to submit comments and questions, through the Parties' website: http://becomingbettertogether.org. A record of community stakeholder and consumer views of the proposed Cooperative Agreement is attached as **Exhibit 10.2**.

11. SIGNED COPY OF THE COOPERATIVE AGREEMENT

RESPONSE: A signed copy of the Cooperative Agreement (referred to by the Parties as the "Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance") is attached hereto as **Exhibit 11.1**.

a. **REQUEST**: A description of any consideration passing to any person under the Cooperative Agreement including the amount, nature, source and recipient.

RESPONSE: No consideration will pass between the Parties under the Cooperative Agreement. In order to preserve the assembled workforce, the Parties intend to pay retention consideration to key employees. The executive officers of the New Health System will enter into employment agreements consistent with their duties and responsibilities. Their compensation will be fair market value as confirmed by an independent valuation firm and consistent with IRS guidelines, and a significant portion of compensation will be based on performance. At the commencement of the strategic options process, Wellmont instituted a retention policy for its key executives. Likewise, Mountain States adopted a retention policy as it commenced negotiation of the Cooperative Agreement. As a result of the Cooperative Agreement, some positions will be eliminated. Those positions will be entitled to customary severance associated with that position. The New Health System anticipates executing new employment agreements, service agreements, and vendor agreements once the COPA has been granted, but none have been executed to date.

The Cooperative Agreement involves no brokers or finders fees. No professionals advising Wellmont, Mountain States, or the New Health System on matters related to the Cooperative Agreement are being compensated on a contingency basis.

b. **REQUEST**: A detailed description of any merger, lease, change of control or other acquisition or change in ownership of the assets of any party to the Cooperative Agreement.

RESPONSE: The Parties plan to cause a new, independent public benefit, not for profit, tax-exempt corporation to be incorporated in Tennessee (the "New Health System"). The New Health System would be governed by a Board of Directors composed of representatives from each legacy board, as well as new community members. The Parties would amend their respective articles and bylaws to designate the New Health System as the sole corporate member of each of the Parties.

The New Health System will be governed exclusively by its board of directors, which is the fiduciary board responsible for the delivery of quality care in

consideration of the needs of the communities served by the system. The New Health System's management team will be composed of current executives from both organizations. The board of directors of the New Health System will be composed 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 will 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). Other senior management positions will be determined at a later date.

After the Closing, the Wellmont and Mountain States entities will continue in existence and the boards of both of those entities will be identical to the New Health System board. The New Health System board will oversee all of the assets and operations of the previously separate Parties and all of their respective Affiliates on the terms and conditions set forth in the Cooperative Agreement 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.

c. **REQUEST**: A list of all services and products and of all service locations that are the subject of the Cooperative Agreement, including those not occurring within the boundaries of the State of Tennessee, and including, but not limited to, hospitals or other inpatient facilities, insurance products, physician practices, pharmacies, accountable care organizations, psychiatric facilities, nursing homes, physical therapy and rehabilitation units, home care agencies, wellness centers or services, surgical centers or services, dialysis centers or services, cancer centers or services, imaging centers or services, support services or any other product, facility or service.

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.

d. **REQUEST**: A description of each party's contribution of capital, equipment, labor, services or other value to the transaction.

RESPONSE: The Parties intend for the Cooperative Agreement to include all assets, ownership interests, subsidiaries and controlled affiliated businesses currently owned or operated, in whole or in part, directly or indirectly, by the respective Parties at the time the COPA is granted. An organizational chart identifying all of the subsidiaries and affiliates of Mountain States is attached as **Exhibit 11.2**. An organizational chart identifying all of the subsidiaries and affiliates of Wellmont is attached as **Exhibit 11.3**.[45]

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: Please see response to item 11.c.

(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[46] as follows:

Table 11.1 – Share of CY2014 Discharges, Current Systems[47]

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

[45] Wellmont has publicly announced its plan to repurchase Takoma Regional Hospital ("Takoma") in Greeneville, Tennessee. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

[46] 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**.

[47] Shares for this table were calculated defining general acute care services excluding normal newborns (DRG 795).

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 system's discharges.[48] Other Mountain States and Wellmont hospitals individually contribute less than one to two percent (1-2%) to the total discharge volume accounted for by their respective parent system.

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

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

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

Due to the large independent physician community in the Geographic Service Area, the Parties do not expect a material change in the shares for physician services. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. Even in overlap specialties, there are substantial competitive alternatives as reflected in the number of independent physicians in the specialty. **Table 11.3**[49] 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.

[48] These three hospitals account for 42.3% of discharges by all hospitals in the Geographic Service Area.

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

[50] 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[51]
Grand Total (Overlap/Non-Overlap)		**2,142**	**70%**	**9%**	**17%**	**4%**
Allergy and Immunology	-	5	100%	0%	0%	0%
Child Development	-	1	100%	0%	0%	0%
Colorectal Surgery	-	2	100%	0%	0%	0%
Dentistry	-	8	100%	0%	0%	0%
Hand Surgery	-	2	100%	0%	0%	0%
Maternal and Fetal Medicine	-	2	100%	0%	0%	0%
Neonatology	-	8	100%	0%	0%	0%
Ophthalmology	-	35	100%	0%	0%	0%
Optometry	-	1	100%	0%	0%	0%
Oral Surgery	-	11	100%	0%	0%	0%
Pathology	-	24	100%	0%	0%	0%
Pediatric Dentistry	-	7	100%	0%	0%	0%
Pediatric Emergency Medicine	-	3	100%	0%	0%	0%
Pediatric Gastroenterology	-	2	100%	0%	0%	0%
Pediatric Hematology Oncology	-	2	100%	0%	0%	0%
Pediatric Nephrology	-	1	100%	0%	0%	0%
Pediatric Pulmonology	-	1	100%	0%	0%	0%
Pediatric Surgery	-	1	100%	0%	0%	0%
Perfusionist	-	1	100%	0%	0%	0%
Physician Assistant	-	55	100%	0%	0%	0%
Plastic Surgery	-	13	100%	0%	0%	0%
Podiatry	-	20	100%	0%	0%	0%
Radiology	-	186	100%	0%	0%	0%
Rheumatology	-	6	100%	0%	0%	0%
Sports Medicine	-	3	100%	0%	0%	0%
Telemedicine	-	2	100%	0%	0%	0%
Teleradiology	-	10	100%	0%	0%	0%

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

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

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

A large number of independent providers of outpatient services compete in the Geographic Service Area. In many outpatient services, including imaging, surgery and urgent care, independent providers account for at least a fifty percent (50%) share. **Table 11.5**[52] depicts counts and share numbers for categories of outpatient services based on the affiliation of the providers:

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

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

(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.

COMMITMENTS

- 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

- With academic partners in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.

- The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.

g. **REQUEST**: Description of financial performance, including:

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

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

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

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

(iii) A detailed explanation of the projected effects including expected change in volume, price and revenue as a result of the Cooperative Agreement, including;

I. Identification of all insurance contracts and payer agreements in place at the time of the Application and a description of pending or anticipated changes that would require or enable the parties to amend their current insurance and payer agreements;

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

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

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

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

Any pricing limitations agreed to by the New Health System are intended to benefit employers and those who are shouldering the burden of what is projected to be increased overall health care costs in the coming years. This burden has increasingly fallen on consumers who have seen dramatic increases in the deductibles they are required to pay. Unregulated merged systems do not provide for limitations on commercial payment increases, which can negatively impact self-insured employers, employees and insurers who are managing risk. Conversely, the New Health System has committed to a reduction in price increases and set a new, lower cost trend for many third party payers. These pricing commitments are proposed so as to pass savings on to consumers through their chosen insurers resulting from the efficiencies the New Health System expects to achieve.

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.

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

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

In addition, as a result of the merger, the Parties project that the merger will result in improved quality of care and enhanced clinical coordination. This capability will enable the system to participate meaningfully in various federal and commercial efforts to share risk and take advantage of the scalable ability of the New Health System to better manage the care for high cost, high utilization patients.

Through this effort, these changes will result in fewer hospitalizations and reduced lengths of stay when patients are hospitalized. Insurers and insured consumers will benefit through lower expenditures for inpatient care when patients spend less time in the hospital or are able to avoid hospitalizations altogether.

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

III. The following policies:

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

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

that are substantially similar to the existing policies of both Parties.[53] Specifically, the Parties intend to address each category of patients as follows:

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

[53] *See* **Exhibit 11.1**, Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance, Section 1.02 “Community Benefit."

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.

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

- The board of directors of the New Health System will be comprised of fourteen voting members, as well as two ex-officio

voting members and one ex-officio non-voting member. Wellmont and Mountain States will each designate six members to serve on the initial board of the New Health System.

- Wellmont and Mountain States will jointly select two members of the initial New Health System board, who would not be incumbent members of either Party's board of directors.

- The two ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The ex-officio non-voting member will be the then current President of ETSU.

- The New Health System will have a new name and will be managed by an executive team with representatives from each organization serving in the following agreed-upon roles—Executive Chairman/President Alan Levine (currently Mountain States' CEO), CEO Bart Hove (currently Wellmont's CEO), Chief Operating Officer Marvin Eichorn (currently Mountain State's Chief Operating Officer) and Chief Financial Officer Alice Pope (currently Wellmont's Chief Financial Officer).

- All Board committees of the New Health System will be established with initial membership of equal representation from both legacy organizations. Likely committees will include: Executive, Finance; Audit and Compliance; Quality, Service and Safety; Executive Compensation; Workforce; Community Benefit; and Governance/Nominating.

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

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

The New Health System is committed to its current workforce and will honor prior service credit, address any differences in salary/pay rates and benefits, offer competitive salaries, and combine the best of each

hospital's career development programs as described more fully in **Section 11.f**.

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

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

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

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

proposal.

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

COMMITMENTS

- For all Principal Payers,* the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the system.

- Adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services and facilitate the move to value-based contracting.

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

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

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

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

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

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

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

1. Non-Labor Efficiencies. The Parties have comparable size, and each has multiple facilities. Their purchasing needs are similar, including non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals. The larger, combined enterprise of the New Health System will be able to generate significant purchasing economies. These non-labor efficiency savings would include

    - Harmonization to a Common Clinical IT platform
    - Consolidation of purchased services (Blood/Blood products, Anesthesia, Legal, Marketing, Executive Recruitment, etc.)
    - Reductions in unnecessary duplication of Call Pay
    - Reductions in Locum Tenens and use of “Registry Staff”
    - Renegotiations of service, maintenance, and other contracts
    - Reductions in the duplication of subscriptions, memberships, licenses and other similar payments and
    - Added economies and efficiencies gained from the larger size of the New Health System.

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

2. Labor Efficiencies. The workforce is the lifeblood of a health care organization, and the competition for the labor force will remain intense, both locally and regionally. As stated in **Section 6** herein, the majority of outpatient services will not be controlled by the New Health System, and other very significant inpatient providers are located nearby. Thus, the New Health System will remain competitive as it relates to salary and benefit

offerings, and will be committed to the ongoing development of its workforce. As discussed in **Section 11.f**, the Parties are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Parties have identified potential savings from the merger in labor expenses totaling approximately $25 million annually. These savings could extend across a variety of departments and areas:

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

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

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

process without the full and complete participation of community stakeholders after the COPA is granted.

3. Clinical Efficiencies. The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most effective levels of services at the right locations. To ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy (discussed in **Section 11.h.ii**) that will allow the New Health System to utilize a rigorous, systematic method to evaluate the potential merits and adverse effects related to access, quality and service for patients and make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The clinical efficiencies generated by the Alignment Policy will result in operating efficiencies, improved quality and improved access that would not be accomplished without the merger. The anticipated clinical efficiencies generated by the New Health System are largely driven by the New Health System's ability to align duplicative health care services for better care delivery. Cost-saving and efficiency opportunities for the New Health System include consolidation of the area's two Level I Trauma Centers, consolidation of specialty pediatrics services, repurposing acute care beds and consolidation of certain co-located ambulatory facilities. The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

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

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

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

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.

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

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

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

  RESPONSE: The New Health System is committed to improving community health through investment of not less than $75 million over ten years in science and evidence-based population health improvement. Combining the region's two major health systems in an integrated delivery model is the best way to identify regional priorities, collaborate with payers to identify cost drivers and areas of need for improvement and to invest the resources it will take to effect material improvements. These efforts will provide resources that may be invested in more focused and meaningful value-based spending in the region – spending that helps expand currently absent, but necessary, high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. The New Health System would commence this process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for improvement over the next decade. The health improvement plan would be prepared in conjunction with the public health resources at ETSU. The process has already commenced through the four Community Health Work Groups described herein. Population health improvement funding may be committed to the following initiatives, as well as others based upon the 10-year plan for the region.

  - ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.

  - ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.

  - ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

The Parties believe that prevention services, such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services, are all essential ingredients in achieving population health improvements and maintaining a population's long-term health and wellness. Certain counties in the service area have achieved noteworthy performance in specific areas. For example, the Northeast region[54] 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

[54] 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.

geographic barriers and can be further supplanted by a host of health IT and telemedicine strategies which are envisioned to be developed as part of the long-range community health improvement plan. Both organizations operate nurse call centers which are able to engage with populations for the development of wellness and prevention coaching and disease management programming to help overcome geographic and social barriers.

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

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

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

  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 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

Index of Public Advantage and Community Health Improvement **A. Commitment to Improve Community Health Measures**		
	Commitment	*Proposed Accountability Mechanism*
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:

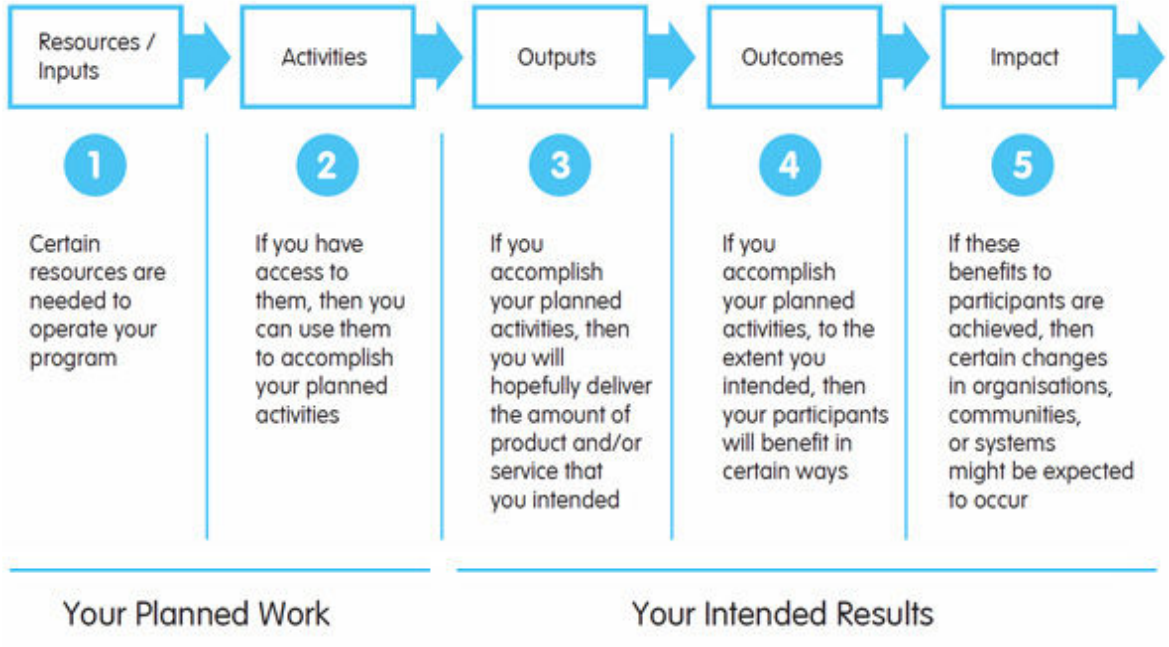
Proposal for Development of the Commitment to Community Health Annual Report

- 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.
- 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



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. [55] 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.

[55] 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

	Health Concern	*Health Concern **Tracking Measures** in the TN & VA Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[56]
Key Focus Area #1: Ensure Strong Starts for Children							
1.	Low Birth-Weight Babies	Low-birth weight rate per 100,000 population	Establish evidence-based Home Visitation Programs in certain high-risk counties[57]	Establish agreed- upon number of evidence-based Home Visitation Programs[58] in specific counties by set date	Percentage of eligible women in high-risk communities participating in evidenced-based Home Visitation Programs	Johnson, Carter, Cocke[59]	Tazewell, Buchanan, Smyth[60]
2.	Neonatal Abstinence Syndrome	Percent of Births in New Health System with NAS	Establish residential treatment for pregnant woman with addiction in certain high-risk communities[61]	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[62]	Dickenson, Wise, Tazewell, Buchanan[63]

[56] This column is based on data that includes the Virginia counties and Independent Cities within the Geographic Service Area.
[57] 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**.
[58] 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.
[59] Tennessee: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.
[60] Virginia: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.
[61] 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**.
[62] 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.
[63] 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.

Health Concern		*Health Concern* ***Tracking Measures*** *in the TN & VA Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[56]
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[64]	Expand "Morning Mile[65]" 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[66]	Russell, Scott, Grayson, Washington, Wise[67]
4.	Third Grade Reading Ability	Percent 3rd graders reading at grade level	Expand "Bear Buddy" program[68]	Expand "BEAR Buddies[69]" program through investment of an agreed-upon amount by set date	Number of children participating in BEAR Buddies in TN & VA in high-risk communities	Hancock, Cocke, Carter[70]	Bristol City, Buchanan, Wythe[71]

[64] 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**.

[65] 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

[66] 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.

[67] 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.

[68] 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**.

[69] 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.

[70] Tennessee: TCAP District Level Results – 3rd through 8th Grade Reading Level. Percent Basic through Percent Advanced. Tennessee Department of Education. Accessed February 4, 2016.

[71] Virginia: SOL Assessment – 3rd Grade English Reading Pass Rate for 2014 - 2015. Virginia Department of Education. Accessed February 4, 2016.

Health Concern		*Health Concern **Tracking Measures** in the TN & VA Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[56]
Key Focus Area #2: Help Adults Live Well in the Community							
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[72]	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[73]	Tazewell, Smyth, Scott[74]
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[75]	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[76]	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[77]	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[78]	Bristol City, Smyth, Buchanan[79]

[72] 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**.
[73] "Ischemic Heart Disease in Tennessee." US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/.
[74] "Ischemic Heart Disease in Virginia." US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/.
[75] 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**.
[76] 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/.
[77] 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**.
[78] Tennessee: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer 2014. CDC Wonder Database. Accessed February 3, 2016.

	Health Concern	*Health Concern* ***Tracking Measures*** *in the TN & VA Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[56]
Key Focus Area #3: Promote a Drug-Free Community							
1.	Addiction to Prescription Pain-killers and illicit drugs	Addiction death rate per 100,000	Establish a regional residential addiction treatment program[80]	Establishment of a regional residential addiction treatment program by a set date	Number of individuals participating in residential addiction treatment	Hancock, Hamblen, Hawkins[81]	Dickenson, Wise, Tazewell, Buchanan[82]
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[83]	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[84]	Wise, Dickenson, Buchanan[85]
Key Focus Area #4: Decrease Avoidable Hospital Admission in the High-Utilizing Uninsured							
1.	Avoidable inpatient admission among the uninsured	PQI Admissions per 1,000 uninsured	Establish Integrated Care Management Program for Uninsured Community Super-Utilizers[86]	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[87]	Buchanan, Russell, Lee[88]

[79] Virginia: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer, 2014. CDC Wonder Database. Accessed February 3, 2016.
[80] 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**.
[81] Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.
[82] Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.
[83] 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**.
[84] 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.
[85] 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.
[86] 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**.

Health Concern		*Health Concern **Tracking Measures** in the TN & VA Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[56]
Key Focus Area #5: Access to Behavioral Health Services							
1.	Access to community-based mental health treatment	Psychiatric Admissions through ER per 1,000 ER visits	Establish Crisis Receiving Centers in hospitals serving specific high-risk counties[89]	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[90]	Wise, Dickenson, Tazewell[91]

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.

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[87] 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.

[88] 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.

[89] 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.**

[90] 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.

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

Periodic Review of the Commitment to Community Health Annual Report

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

B. Enhanced Health Care Services Measures

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

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

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

Table 11.8 - Proposed Enhanced Health Care Services Measures

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

C. Expanding Access and Choice Measures

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

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

proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.9 - Proposed Expanding Access and Choice Measures

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

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

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

As evidence of their commitment to manage quality, cost, and service, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to improve health care value. **Table 11.10** below indicates ten areas where the Parties have made

commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

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

Index of Public Advantage and Community Health Improvement **D. Improving Health Care Value: Managing Quality, Cost and Service Measures**		
	Commitment	*Proposed Accountability Mechanism*
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 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.	Annual report to State attesting to compliance.

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.
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.
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.
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.
7.	The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.	Annual report to State attesting to measurement of quality measures identified in **Section 8(A)(iv)** of the COPA Application.
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.
9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.
10.	The New Health System will not engage in “most favored nation” pricing with any health plans.	Annual report to State attesting to compliance.
* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.		

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

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

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

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

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

Index of Public Advantage and Community Health Improvement **E. Investment in Health Education/Research and Commitment to Workforce Measures**		
	Commitment	*Proposed Accountability Mechanism*
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 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.
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

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
A. Commitment to Improve Community Health			
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.	Satisfied
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

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
B.	**Enhanced Health Care Services Measures**		
1.	The New Health System commits to spending at least $140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to State attesting to progress towards compliance until $140 million is invested.	Satisfied
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.	One-time report to State attesting to the creation of new capacity for residential addiction recovery services when complete.	Satisfied
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.	Report to State attesting to compliance after the third year after formation of the New Health System.	Satisfied
4.	Development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients' homes as possible.	Annual report to State attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.	Satisfied
5.	Development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.	File the Comprehensive Physician Needs Assessment with the State every three years.	Satisfied
C.	**Expanding Access and Choice**		
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.	Annual report to State attesting to compliance for five years after formation of the New Health System.	Satisfied
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

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
3.	Maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors	Annual report to State attesting to compliance.	Satisfied
4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to State attesting to compliance.	Satisfied
5.	Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.	Annual report to State attesting to compliance.	Satisfied
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to State attesting to compliance.	Satisfied
D. Improving Health Care Value: Managing Quality, Cost and Service			
1.	For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.	Report to State after first contract year attesting to compliance.	Satisfied
2.	For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may	Annual report to State attesting to compliance.	Satisfied

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
	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.		
3.	The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.	Annual report to State attesting to compliance.	Satisfied
4.	The New Health System will collaborate with Independent Physician Groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.	Annual report to State attesting to compliance.	Satisfied
5.	The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.	Annual report to State attesting to progress towards compliance until the Common Clinical IT Platform is adopted.	Satisfied
6.	The New Health System will participate meaningfully in a health information exchange open to community providers.	Annual report to State attesting to compliance once health information exchange is fully established.	Satisfied
7.	The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.	Annual report to State attesting to measurement of quality measures identified in **Section 8(A)(iv)** of the COPA Application.	Satisfied
8.	The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates	Annual report to State attesting to compliance.	Satisfied

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
	(subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.		
9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.	Satisfied
10.	The New Health System will not engage in "most favored nation" pricing with any health plans.	Annual report to State attesting to compliance.	Satisfied
E.	**Investment in Health Education/Research and Commitment to Workforce**		
1.	The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.	Annual report to State attesting compliance.	Satisfied
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
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.	Satisfied

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

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

Table 11.13 - Demonstration of Overall Achievement Scoring

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

Continuing Public Advantage

The Parties propose that an Overall Achievement Score rounded to the nearest tenth of one point that equals seventy percent (70%) or above shall be considered clear and convincing evidence of the Public Advantage and the COPA shall continue in effect. An Overall Achievement Score rounded to the nearest tenth of one point that equals fifty percent (50%) up to seventy percent (70%) may be considered clear and convincing evidence of the Public Advantage depending upon the relative circumstances, and the State, at the Commissioner's discretion, may seek a modification to the Cooperative Agreement under the terms of the COPA. An Overall Achievement Score rounded to the nearest tenth of one point that is below fifty percent (50%) may be considered evidence, when considering the relative circumstances, that the Public Advantage of the COPA is no longer evident and the State, at the Commissioner's discretion, may begin action to terminate the COPA under the terms of the certification.

Due to the new and untested nature of the Index of Public Advantage and Community Health Improvement and the significant up-front and ongoing investments required for achieving community health improvement in the Geographic Service Area, it is critical that the Commissioner use proper discretion in determining whether the evidence of the Public Advantage is clear and convincing. Notwithstanding any provision to the contrary, the Commissioner shall consider any and all important public benefits, whether or not explicitly addressed in the Index of Public Advantage and Community Health Improvement. Further, the Commissioner shall have discretion to determine that

the clear and convincing standard has been achieved during a particular period even if the Overall Achievement Score falls below the parameters outlined.

Representative Examples:

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

Table 11.14 - Sample Scoring for Example 1

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

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

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

Table 11.15 - Sample Scoring of Example 2

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	4/5	
C. Expanding Access and Choice	4/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	6/10	
E. Investment in Health Research/Education and Commitment to Workforce	3/6	
Overall Achievement Score	**19/30**	**63.3%**

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

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

Table 11.16 - Sample Scoring of Example 3

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

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

Index of Public Advantage and Community Health Improvement Conclusion

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

12. EXPLANATION OF THE REASONS FOR THE EXCLUSION OF ANY INFORMATION

REQUEST: Provide an explanation of the reasons for the exclusion of any information set forth in section 1200-38-01-.02, the Application Process, including an explanation of why the item is not applicable to the Cooperative Agreement or to the parties.

RESPONSE: The Parties have excluded the following information from the Application because the information is considered confidential or competitively sensitive under federal antitrust laws. This information will be subsequently filed with the State.

Exhibit 11.4D Mountain States' Covenant Compliance Certificates

Exhibit 11.4E Mountain States' Officer's Certificates accompanying Independent Auditor's Reports

Exhibit 11.5D Wellmont's External Auditor Management Letters

Exhibit 11.6 Current Annual Budget for Mountain States

Exhibit 11.7 Current Annual Budget for Wellmont

Exhibit 11.11 Existing and Future Business Plans of Mountain States

Exhibit 11.12 Existing and Future Business Plans of Wellmont

13. DESCRIPTION OF THE TOTAL COST RESULTING FROM THE COOPERATIVE AGREEMENT

REQUEST: Provide a detailed description of the total cost resulting from the Cooperative Agreement, including, but not limited to, new costs for consultants, capital costs and management costs. The description should identify costs associated with the implementation of the Cooperative Agreement, including documentation of the availability of the necessary funds. The description should identify which costs are borne by each party.

RESPONSE: Commencing with the strategic options process, both Wellmont and Mountain States have incurred consultant and professional expenses in connection with the Cooperative Agreement. These services include business advisory, economist, legal, accounting and other professional services. Each Party has been responsible for its own legal and accounting services. The Parties have agreed to share certain consulting services, such as economist, public relations, and governance, and certain due diligence expenses. The Parties estimate merger-related expenses to be one-time expenses and to total in the aggregate approximately one half of one percent (0.5%) of the annual aggregate net revenue of the New Health System.

Because there is no consideration being exchanged in the transaction, there are no other fees that normally would apply, such as financing, contingency or lending fees. There are no capital expenditures required by the Cooperative Agreement. The Parties anticipate that the New Health System will make expenditures in connection with rebranding, the Common Clinical IT platform, population health, implementation of the health index, new services, and other items discussed more fully elsewhere in this Application.

14. TIMETABLE FOR IMPLEMENTATION OF THE COOPERATIVE AGREEMENT

REQUEST: Provide a timetable for implementing all components of the Cooperative Agreement.

RESPONSE: The Parties intend to follow the proposed timetable set out below for implementation of all components of the Cooperative Agreement:

Action	Date/Target Date
New Health System Articles of Incorporation Filed in Tennessee	September 11, 2015
COPA Letter of Intent Filed in Tennessee	September 16, 2015
Letter of Intent for a Letter Authorizing a Cooperative Agreement Filed in Virginia	September 16, 2015
Mountain States Board Approves Cooperative Agreement	December 15, 2015
Wellmont Board Approves Cooperative Agreement	January 6, 2016
COPA Pre-Submission Report Filed in Tennessee and Virginia	January 7, 2016
Cooperative Agreement is Executed by Both Parties	February 15, 2016
New Health System Interim Directors are Elected and Interim Bylaws are adopted	February 15, 2016
COPA Application Filed in Tennessee	February 16, 2016
Application for a Letter Authorizing a Cooperative Agreement Filed in Virginia	February 16, 2016
Tax-Exemption Application Filed for the New Health System	February 17, 2016 (Target Date)
Tennessee Public Benefit Hospital Sales and Conveyance Act Notice Submitted to the Tennessee Attorney General's Office	April 15, 2016 (Target Date)
Notice Of Disposition Of Assets By Nonprofit Healthcare Entity Submitted to the Virginia Attorney General's office	April 15, 2016 (Target Date)

Action	Date/Target Date
If the COPA is Granted in Tennessee and the Letter Authorizing the Cooperative Agreement is Granted in Virginia:	
New Health System Articles of Incorporation will be Amended	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Bylaws will be Amended	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Initial Directors are Elected	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Board Officers are Elected	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Initial Management Team is Elected	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
Wellmont Board will Adopt Amended and Restated Bylaws Making New Health System its Sole Member	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
Mountain States Board will Adopt Amended and Restated Bylaws Making New Health System its Sole Member	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
Cooperative Agreement Transaction Closes and New Health System Begins Operations	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)

15. PLAN OF SEPARATION

REQUEST: The Department shall require a Plan of Separation be submitted with the Application. The Plan of Separation shall be updated annually by the parties to the Cooperative Agreement. The parties shall provide an independent opinion from a qualified organization verifying the Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the parties.

RESPONSE: The Plan of Separation will focus on a divestiture of assets and operations and any other actions that would be appropriate under then-current market circumstance, to restore, to the extent practicable, competitive conditions to their pre-consolidation state or otherwise remedy the competitive concerns identified. In planning the steps needed to accomplish this, the Parties and the consultant must consider the pre-consolidation competitive state and assess the relevant competitive factors currently applicable to each individual facility's local area, including patient flow patterns, utilization volumes, shares of local rival facilities and concentration levels. This exercise will take into account, for example, the fact that approximately half of the merging systems' current combined share of inpatient services in their combined service area is volume from three hospitals (Bristol Regional Medical Center, Holston Valley Medical Center and Johnson City Medical Center), and that each of these hospitals has an inpatient share in its own service area that is similar in size or larger. Most other hospitals in each system are in largely rural counties, offer fifty or fewer staffed beds and report an average daily census between one and three dozen patients. In only a minority of areas within the combined service area do the parties face each other with competing hospitals in close proximity to each other, and in various areas the parties have competition from third-party hospitals. Outpatient services competition has its own set of unique characteristics across different parts of the combined service area. The Plan of Separation will recommend divestitures and remedial steps, as applicable, designed to restore these competitive dynamics. Please see the Plan of Separation attached as **Exhibit 15.1**.

The Plan of Separation has been reviewed by FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm. FTI Consulting, Inc. has issued an opinion verifying that the Parties' Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the Parties. A copy of the opinion is attached as **Exhibit 15.2**.

16. AUTHORIZED PERSONS TO RECEIVE NOTICES, REPORTS & COMMUNICATIONS

REQUEST: Provide the name, address and telephone number of the person(s) authorized to receive notices, reports and communications with respect to the Application.

RESPONSE: The individuals authorized to receive notices, reports and communications with respect to the Application are as follows:

For Mountain States:

Barbara Allen
Chairman of the Board
3300 Browns Mill Rd
Johnson City, TN 37604
423-282-4841

Alan Levine
President & Chief Executive Officer
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604
423-302-3423

Tim Belisle, Esq.
Senior Vice President-Compliance Officer and General Counsel
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604
423-302-3394

J. Richard Lodge, Esq.
Bass Berry & Sims PLC
Counsel to Mountain States
150 Third Avenue South, Suite 2800
Nashville, TN 37201
615-742-6254

For Wellmont:

Roger Leonard
Chairman of the Board
102 Oakview Circle
Bristol, TN 37620
423-652-2204

Bart Hove
President & Chief Executive Officer
1905 American Way
Kingsport, Tennessee 37660
423-230-8219

Gary Miller, Esq.
Senior Vice President, Legal Affairs, and General Counsel
1905 American Way
Kingsport, Tennessee 37660
423-230-8204

Richard G. Cowart, Esq.
Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C.
Counsel to Wellmont
211 Commerce Street, Suite 800
Nashville, TN 37201
615-726-5660

17. LIST OF EXHIBITS AND ATTACHMENTS

Exhibit Number	Description
Exhibit 5.1 - Attachment A	Service Area
Exhibit 5.1 - Attachment B	Hospital Draw Areas and Summary Statistics
Exhibit 5.1 - Attachment C	Geographic Service Area Payer Mix
Exhibit 5.2	Shares for New Health System
Exhibit 6.1 - Attachment A	Outpatient Facilities
Exhibit 6.1 - Attachment B	Urgent Care Centers
Exhibit 6.1 - Attachment C	CT/MRI Capabilities
Exhibit 6.1 - Attachment D	Ambulatory Surgical Centers
Exhibit 6.1 - Attachment E	Physician Services
Exhibit 8.1 - Attachment A	County Health Rankings for Tennessee Counties within the Geographic Service Area
Exhibit 8.1 - Attachment B	County Health Rankings for Virginia Counties and Independent Cities within the Geographic Service Area
Exhibit 8.2 - Attachment A	Work Group Charters
Exhibit 8.2 - Attachment B	Work Group Membership Lists
Exhibit 8.3	Schedule of Public Meetings Conducted by the Work Groups
Exhibit 8.4 - Attachment A	Mountain States' Charity Care Policy
Exhibit 8.4 - Attachment B	Mountain States' Credit and Collection Policy - Patient Accounts
Exhibit 8.4 - Attachment C	Mountain States' Collection Agency Process - Fiscal Services
Exhibit 8.4 - Attachment D	Mountain States' Code of Ethics and Business Conduct
Exhibit 8.5 - Attachment A	Wellmont's Charity Care Policy and Related Policies
Exhibit 8.5 - Attachment B	Wellmont Patient Bill of Rights
Exhibit 8.5 - Attachment C	Wellmont Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy
Exhibit 10.1	Pre-Submission Report
Exhibit 10.2	Record of Community Stakeholder and Consumer Views
Exhibit 11.1	Signed Copy of the Cooperative Agreement
Exhibit 11.2	Organizational Chart of Mountain States
Exhibit 11.3	Organizational Chart of Wellmont
Exhibit 11.4	Financial Summary for Mountain States
Exhibit 11.4 - Attachment A	Mountain States Bonds Official Statement for 2011 bonds

Exhibit Number	Description
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
Exhibit 15.1	Plan of Separation
Exhibit 15.2	Opinion on Plan of Separation

Exhibit 5.1

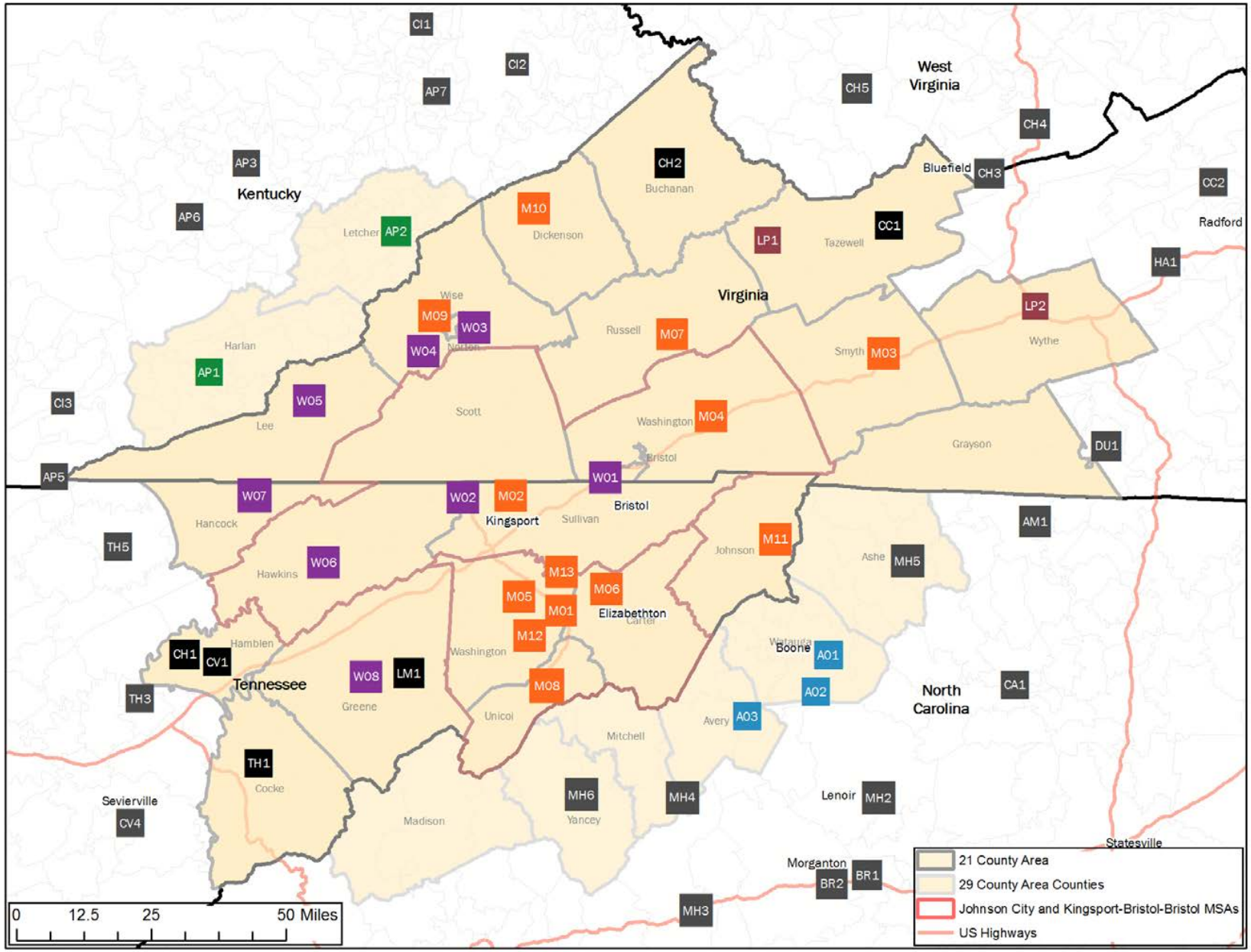
A. Service Area Definitions

Service areas were derived for each Wellmont and Mountain States hospital using patient discharge data for CY2014 from Tennessee and Virginia for all hospitals using standard methodologies for sorting zip codes from largest to smallest number of discharges:

Service areas were defined based on 75% and 90% discharge areas for general acute care patients (less normal newborns defined as DRG 795) and all payors. Service areas for Quillen and Woodridge were defined using the services they provide. Service areas are depicted for each hospital using maps and a table of the zip codes.

Summary statistics on licensed and staffed beds, occupancy and ADC were developed from reports filed by Wellmont and Mountain States with state agencies in Tennessee and Virginia[1]; trend data are provided and summary statistics are reported for the latest available year (2013).

[1]Sources: Tennessee Joint Annual Reports FY10-FY13; Virginia Health Information Reports FY10-FY13. The Tennessee Joint Annual Reports can be found at https://apps.health.tn.gov/publicjars/default.aspx. The Virginia Health Information Reports were provided by the Parties.


CI1
CI2
AP7
CH5
West Virginia
CH4
AP3
Kentucky
CH2
Buchanan
Bluefield
CH3
CC2
AP6
M10
Dickenson
Radford
Letcher
AP2
LP1
Tazewell
CC1
HA1
Virginia
Wise
M09
W03
LP2
Russell
M07
Wythe
W04
Norton
Smyth
M03
Harlan
AP1
W05
CI3
Scott
Washington
M04
Lee
Grayson
DU1
Bristol
AP5
W01
W07
W02
M02
Bristol
Hancock
Kingsport
Sullivan
AM1
TH5
Johnson
M11
W06
Ashe
MH5
Hawkins
M13
M06
M05
M01
Elizabethton
Carter
M12
Hamblen
Watauga
Boone
A01
CH1
CV1
Washington
W08
LM1
Tennessee
M08
A02
North Carolina
CA1
TH3
Greene
Unicoi
Avery
A03
Mitchell
TH1
Cocke
Sevierville
CV4
MH6
MH4
Lenoir
MH2
Madison
Yancey
Statesville
Morganton
BR2
BR1
MH3
0
12.5
25
50 Miles
21 County Area
29 County Area Counties
Johnson City and Kingsport-Bristol-Bristol MSAs
US Highways

System	State	Hospital Name	Symbol
Mountain States Health Alliance	TN	Johnson City Medical Center	M01
	TN	Indian Path Medical Center	M02
	VA	Smyth County Community Hospital	M03
	VA	Johnston Memorial Hospital	M04
	TN	Franklin Woods Community Hospital	M05
	TN	Sycamore Shoals Hospital	M06
	VA	Russell County Medical Center	M07
	TN	Unicoi County Memorial Hospital	M08
	VA	Norton Community Hospital	M09
	VA	Dickenson Community Hospital	M10
	TN	Johnson County Community Hospital	M11
	TN	Woodridge Hospital	M12
	TN	Quillen Rehabilitation Hospital***	M13
Wellmont Health System	TN	Wellmont Bristol Regional Medical Center	W01
	TN	Wellmont Holston Valley Medical Center	W02
	VA	Mountain View Regional Medical Center	W03
	VA	Wellmont Lonesome Pine Hospital	W04
	VA	Lee Regional Medical Center *(Closed)* *	W05
	TN	Wellmont Hawkins County Memorial Hospital	W06
	TN	Wellmont Hancock County Hospital	W07
	TN	Takoma Regional Hospital *(Independent)* **	W08
Alliant Management Services	NC	Alleghany Memorial Hospital	AM1
Appalachian Regional Healthcare, Inc.	KY	Harlan ARH Hospital	AP1
	KY	Whitesburg ARH Hospital	AP2
	KY	Hazard ARH Regional Medical Center	AP3
	KY	Williamson ARH Hospital	
	KY	Middlesboro ARH Hospital	AP5
	KY	Mary Breckinridge ARH Hospital	AP6
	KY	McDowell ARH Hospital	AP7
Appalachian Regional Healthcare System	NC	Watauga Medical Center	A01
	NC	Blowing Rock Hospital	A02
	NC	Charles A. Cannon Memorial Hospital	A03
LifePoint Hospitals, Inc.	VA	Clinch Valley Medical Center	LP1
	VA	Wythe County Community Hospital	LP2
Carilion Clinic	VA	Carilion Tazewell Community Hospital	CC1
	VA	Carilion Giles Community Hospital	CC2

System	State	Hospital Name	Symbol
Community Health Systems, Inc.	TN	Lakeway Regional Hospital	CH1
	VA	Buchanan General Hospital	CH2
	WV	Bluefield Regional Medical Center	CH3
	WV	Princeton Community Hospital	CH4
	WV	Welch Community Hospital	CH5
	TN	Fort Sanders Regional Medical Center	
Covenant Health	TN	Morristown-Hamblen Healthcare System	CV1
	TN	Parkwest Medical Center	
	TN	Peninsula Hospital	
	TN	LeConte Medical Center	CV4
Tennova Healthcare	TN	Newport Medical Center	TH1
	TN	Physician Regional Medical Center	
	TN	Jefferson Memorial Hospital	TH3
	TN	Turkey Creek Medical Center	
	TN	Claiborne County Hospital	TH5
	TN	Blount Memorial Hospital	
	TN	University of Tennessee Medical Center	
	TN	Laughlin Memorial Hospital	LM1
	TN	East Tennessee Children's Hospital	
	TN	St. Jude Children's Research Hospital	
Blue Ridge HealthCare	NC	Valdese General Hospital	BR1
	NC	Grace Hospital	BR2
Carolinas HealthCare System	NC	Wilkes Regional Medical Center	CA1
Catholic Health Initiatives	KY	Saint Joseph - Martin	CI1
	KY	Pikeville Medical Center	CI2
	KY	Pineville Community Hospital Association	CI3
	KY	Highlands Regional Medical Center	
Duke LifePoint Healthcare	VA	Twin County Regional Hospital	DU1
HCA	VA	LewisGale Hospital at Pulaski	HA1
Mission Health System	NC	Caldwell Memorial Hospital	MH2
	NC	McDowell Hospital	MH3
	NC	Blue Ridge Regional Hospital	MH4
	NC	Ashe Memorial Hospital	MH5
	NC	Yancey Community Medical Center	MH6
Vanderbilt Health	TN	Vanderbilt University Hospitals	

*Wellmont closed Lee Regional Medical Center ("LRMC") in 2013. The Lee County Hospital Authority purchased the LRMC building from Wellmont in 2015 with plans to reopen the hospital as an independent facility. LRMC is no longer a Wellmont facility and, if reopened, it would not be included in the COPA.

**Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

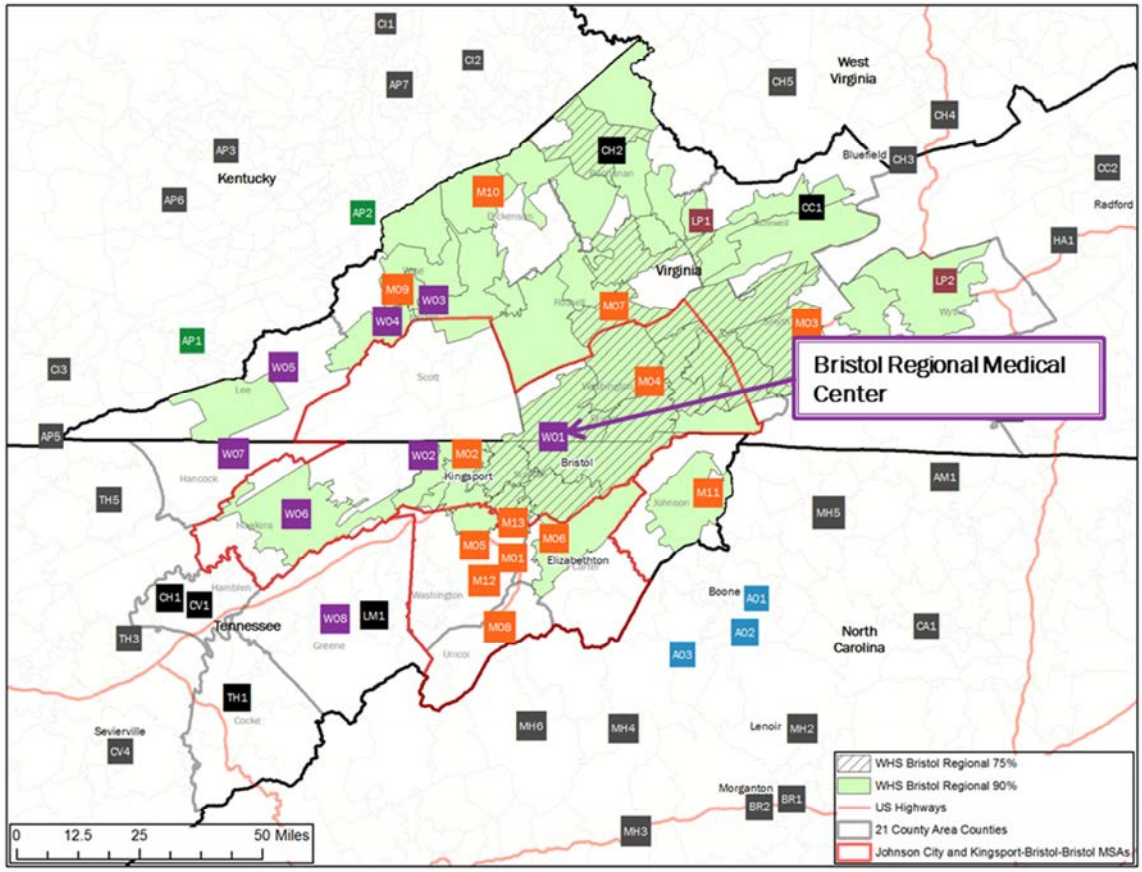
***Mountain States now has a joint venture with HealthSouth to operate Quillen Rehabilitation Hospital.

Some hospitals serving patients from the geographic service area are located outside the area depicted in the map. They are included in the legend for reference.

The Mountain Home VA Medical Center is also located in the Geographic Service Area but is not shown on this map. The Parties compete with this facility for the recruiting and hiring of staff, but do not compete with this facility for patients. The patients that may seek treatment at the Mountain Home VA Medical Center are limited to those individuals that meet certain government-established criteria.

B. Draw Area Maps and Summary Statistics

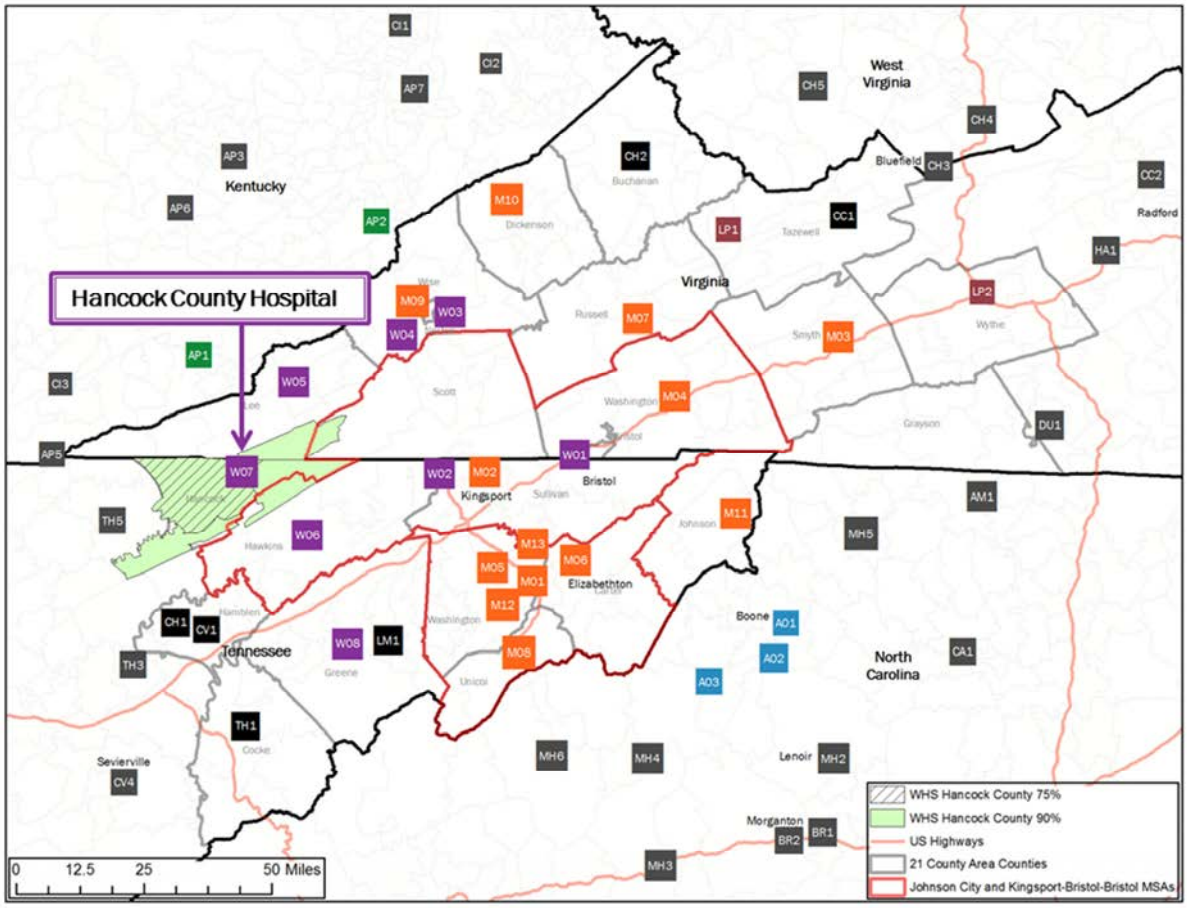
1. Bristol Regional Medical Center



Wellmont Bristol Regional Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	261	261	261	261
Licensed Beds	312	312	312	312
Staffed Beds Occupancy	64.2%	68.0%	66.6%	65.0%
Licensed Beds Occupancy	53.7%	56.9%	55.7%	54.4%
Average Daily Census	167	178	174	170
Patient Days	61,136	64,788	63,609	61,909
Discharges/Admissions	14,044	14,501	14,506	13,742
Average Length of Stay	4.4	4.5	4.4	4.5

Source: Tennessee Joint Annual Report FY10-FY13

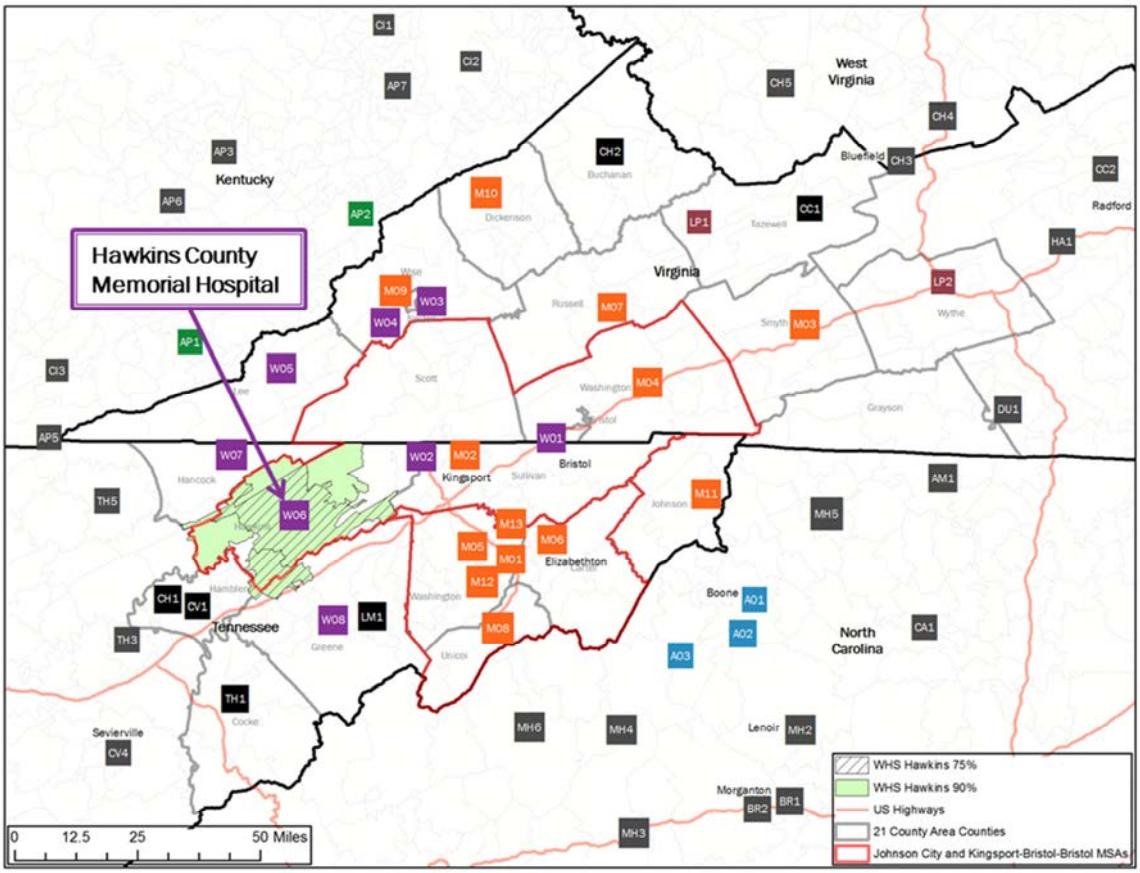
2. Hancock County Hospital



Wellmont Hancock County Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	10	10	10	10
Licensed Beds	10	10	10	10
Staffed Beds Occupancy	27.5%	22.1%	32.8%	30.9%
Licensed Beds Occupancy	27.5%	22.1%	32.8%	30.9%
Average Daily Census	3	2	3	3
Patient Days	1,003	808	1,199	1,127
Discharges/Admissions	327	245	261	242
Average Length of Stay	3.1	3.3	4.6	4.7

Source: Tennessee Joint Annual Reports FY10-FY13

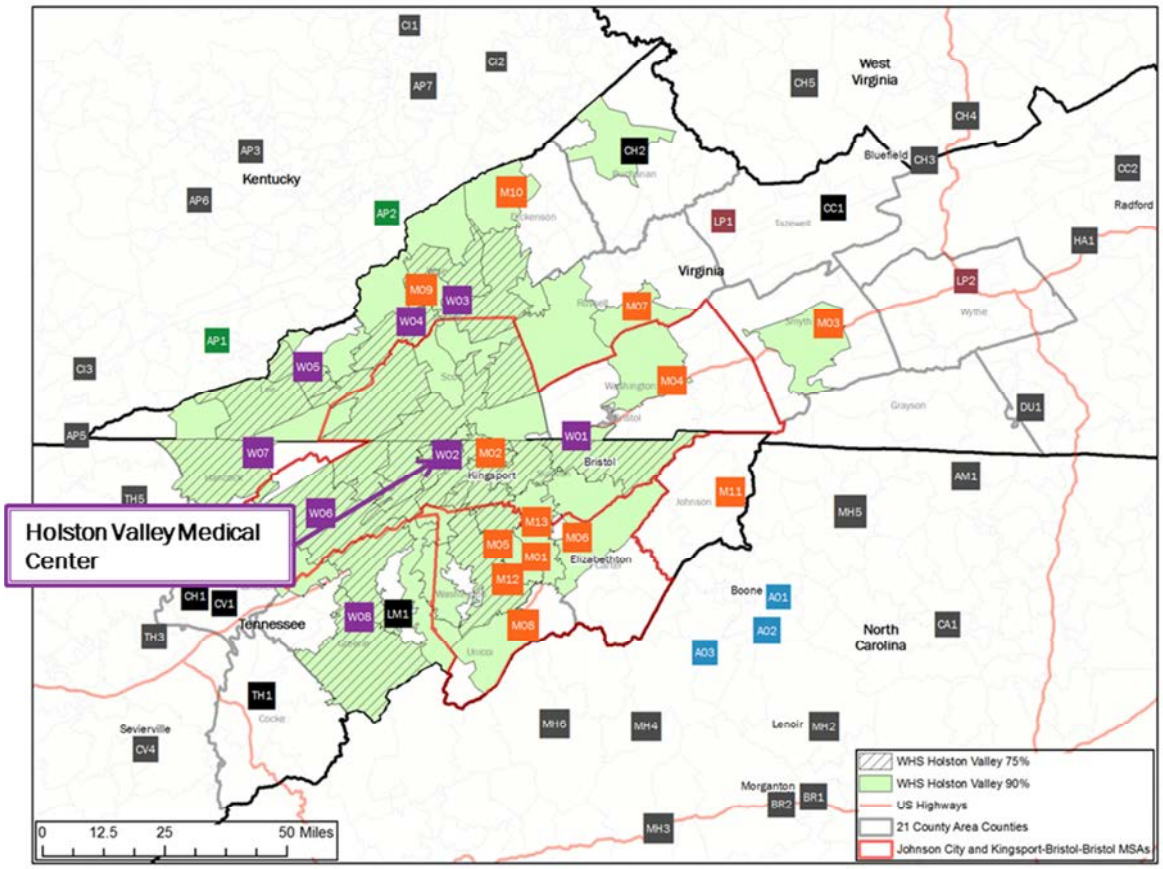
3. Hawkins County Memorial Hospital



Wellmont Hawkins County Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	46	46	46	46
Licensed Beds	50	50	50	50
Staffed Beds Occupancy	30.8%	30.7%	21.0%	18.7%
Licensed Beds Occupancy	28.3%	28.2%	19.3%	17.2%
Average Daily Census	14	14	10	9
Patient Days	5,165	5,153	3,530	3,139
Discharges/Admissions	1,710	1,603	1,291	1,241
Average Length of Stay	3.0	3.2	2.7	2.5

Source: Tennessee Joint Annual Reports FY10-FY13

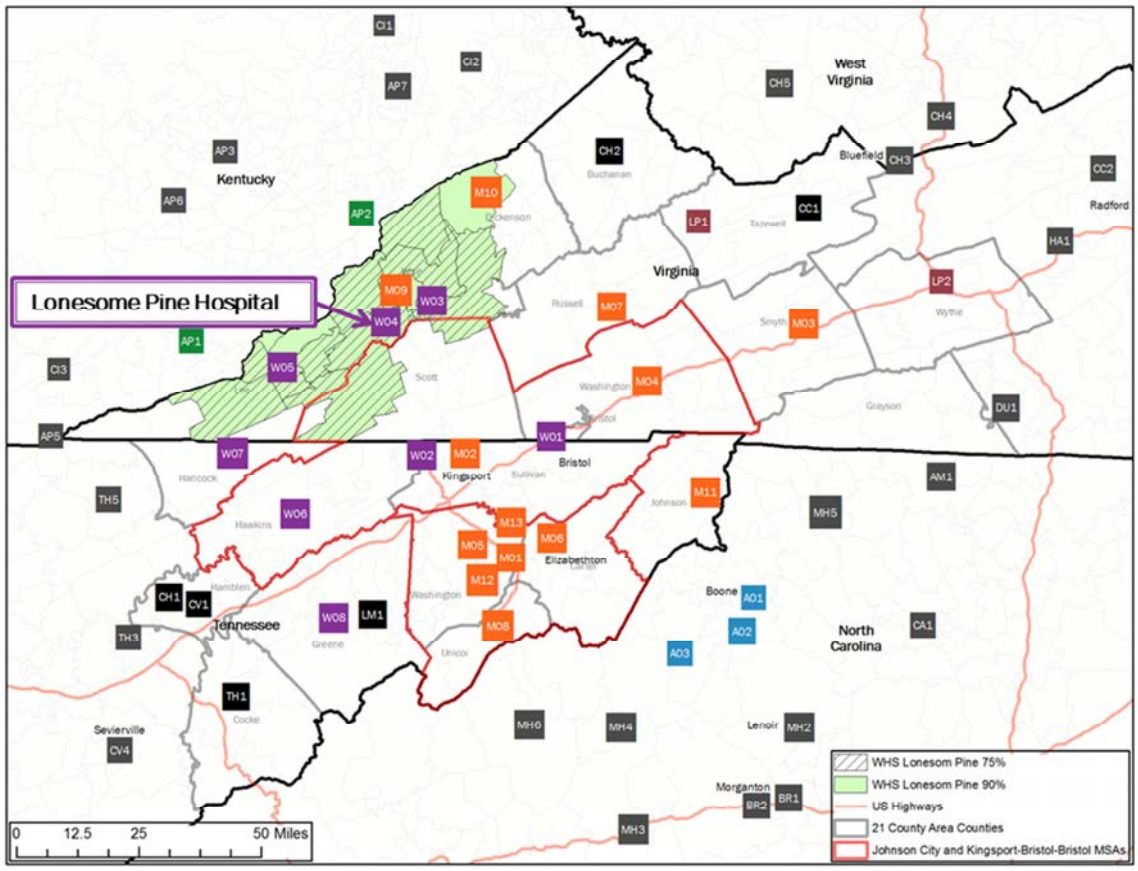
4. Holston Valley Medical Center



Wellmont Holston Valley Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	339	339	339	339
Licensed Beds	505	505	505	505
Staffed Beds Occupancy	69.1%	72.8%	69.9%	66.4%
Licensed Beds Occupancy	46.4%	48.9%	46.9%	44.6%
Average Daily Census	234	247	237	225
Patient Days	85,555	90,104	86,711	82,127
Discharges/Admissions	18,612	19,150	18,451	17,825
Average Length of Stay	4.6	4.7	4.7	4.6

Source: Tennessee Joint Annual Reports FY10-FY13

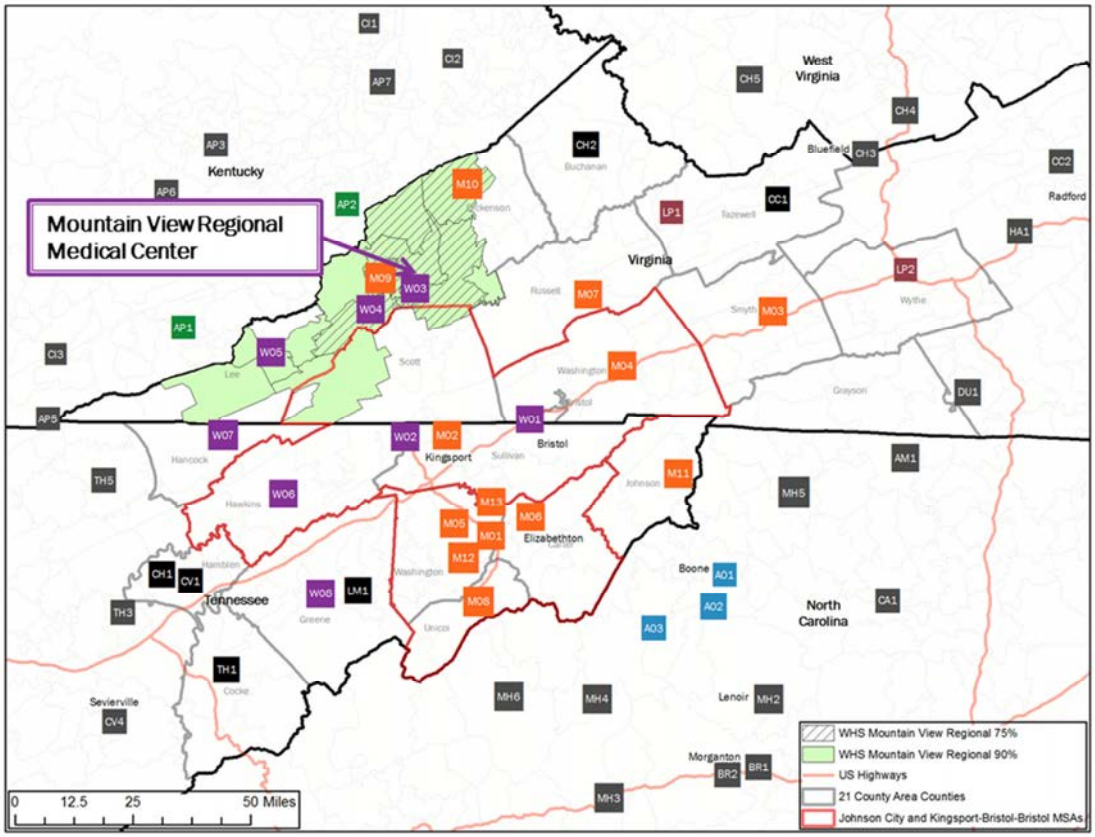
5. Lonesome Pine Hospital



Wellmont Lonesome Pine Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	48	48	60	21
Licensed Beds	60	60	60	60
Staffed Beds Occupancy	45.9%	42.6%	26.0%	49.6%
Licensed Beds Occupancy	36.7%	34.0%	26.0%	17.4%
Average Daily Census	22	20	16	10
Patient Days	8,041	7,455	5,715	3,799
Discharges/Admissions	2,529	2,392	1,955	1,484
Average Length of Stay	3.2	3.1	2.9	2.6

Source: Virginia Health Information Reports FY10-FY13

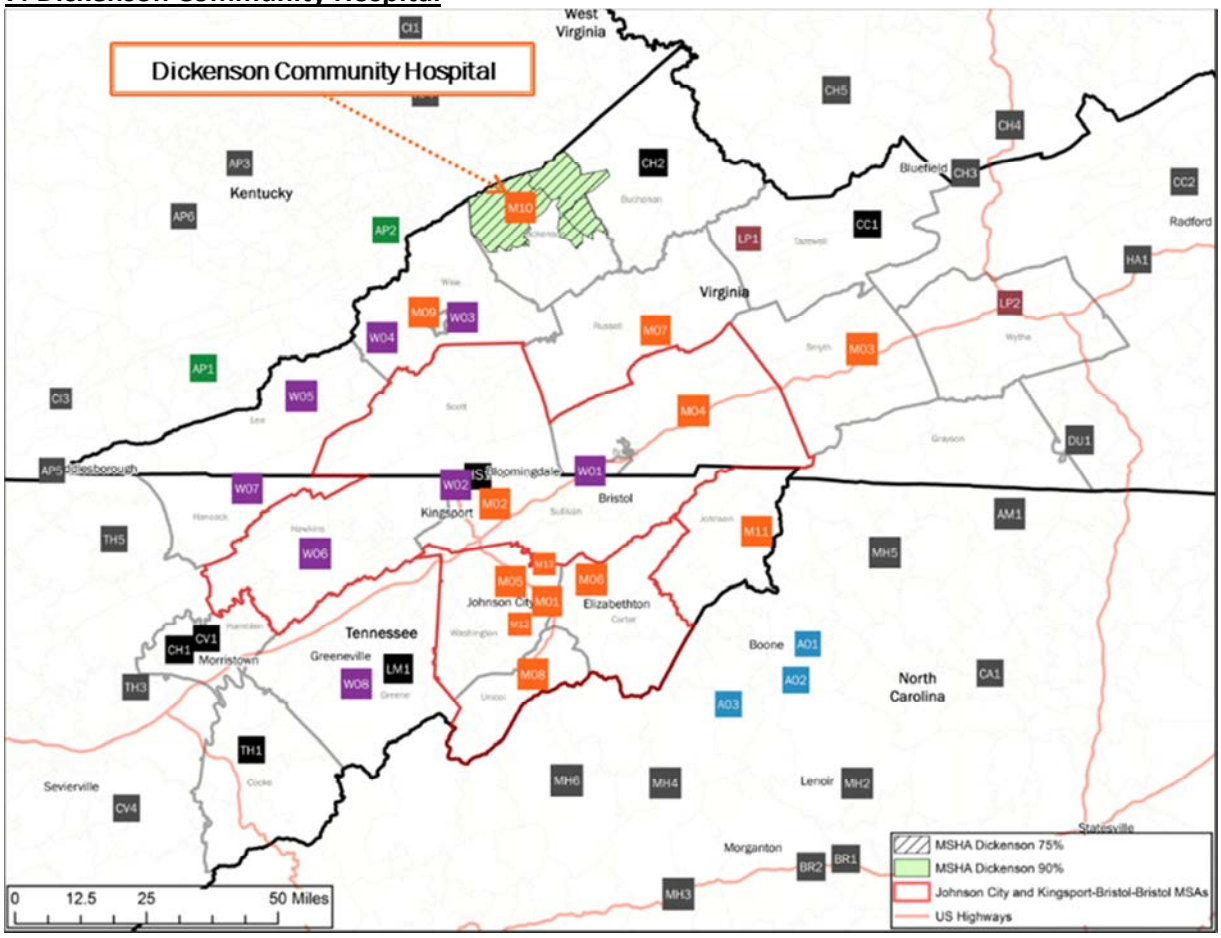
6. Mountain View Regional Medical Center



Wellmont Mountain View Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	17	16	16	18
Licensed Beds	78	74	74	74
Staffed Beds Occupancy	95.6%	98.3%	107.7%	69.5%
Licensed Beds Occupancy	20.8%	21.2%	23.3%	16.9%
Average Daily Census	16	16	17	13
Patient Days	5,929	5,739	6,305	4,565
Discharges/Admissions	1,615	1,716	1,583	1,573
Average Length of Stay	3.7	3.3	4.0	2.9

Source: Virginia Health Information Reports FY10-FY13

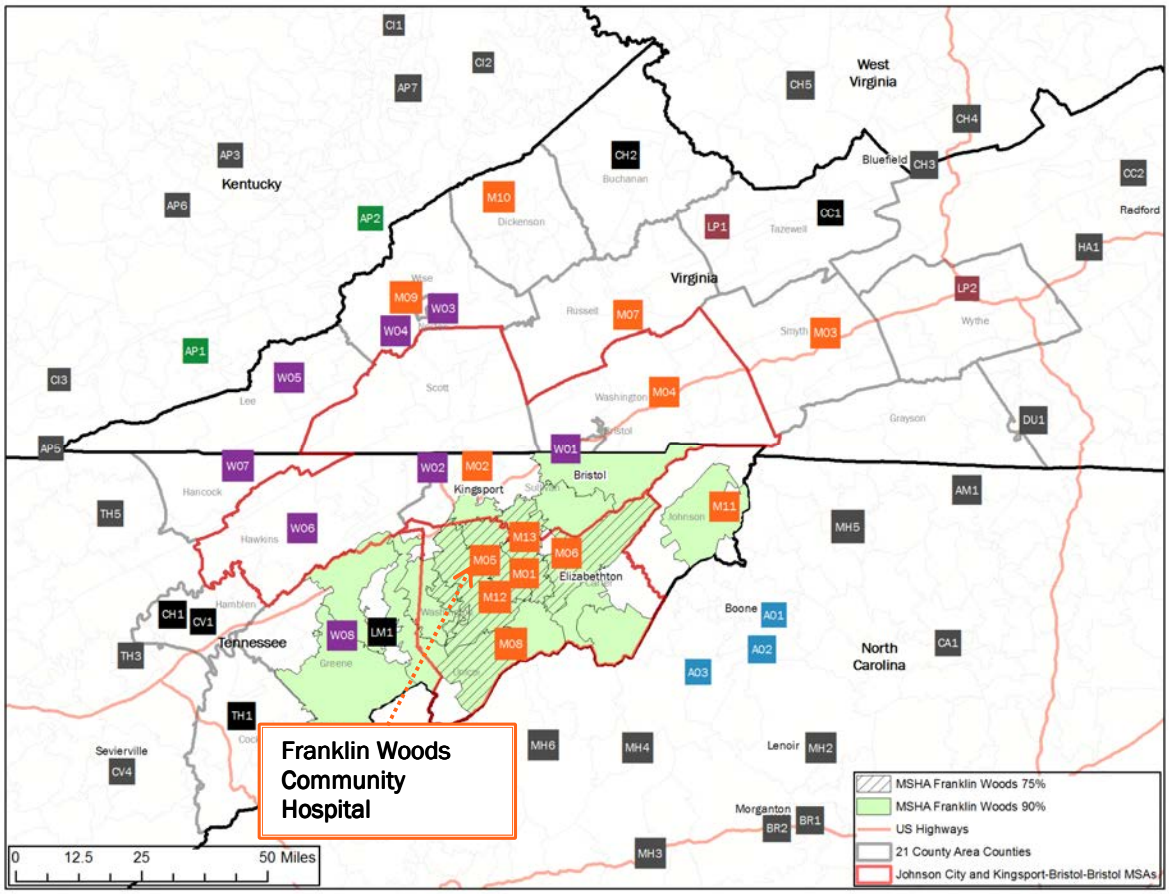
7. Dickenson Community Hospital



Mountain States Dickenson Community Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	1	2	1	2
Licensed Beds	25	25	25	25
Staffed Beds Occupancy	2.7%	0.3%	3.8%	1.6%
Licensed Beds Occupancy	0.1%	0.0%	0.2%	0.1%
Average Daily Census	0	0	0	0
Patient Days	10	2	14	12
Discharges/Admissions	8	1	11	9
Average Length of Stay	1.3	2.0	1.3	1.3

Source: Virginia Health Information Reports FY10-FY13

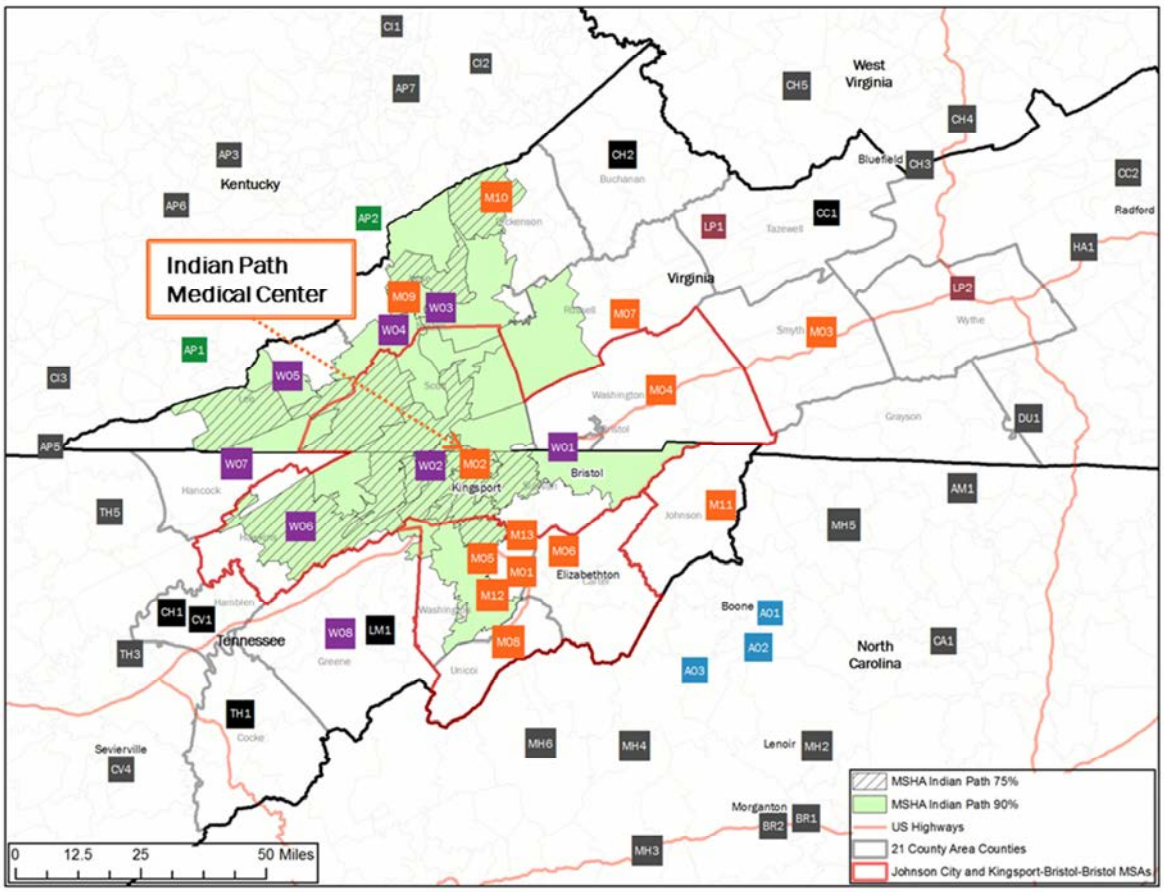
8. Franklin Woods Community Hospital



Mountain States Franklin Woods Comparative Statistics			
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	80	80	77
Licensed Beds	80	80	80
Staffed Beds Occupancy	50.0%	48.6%	54.1%
Licensed Beds Occupancy	50.0%	48.6%	52.1%
Average Daily Census	40	39	42
Patient Days	14,612	14,233	15,199
Discharges/Admissions	3,721	3,719	4,189
Average Length of Stay	3.9	3.8	3.6

Source: Tennessee Joint Annual Reports FY11-FY13

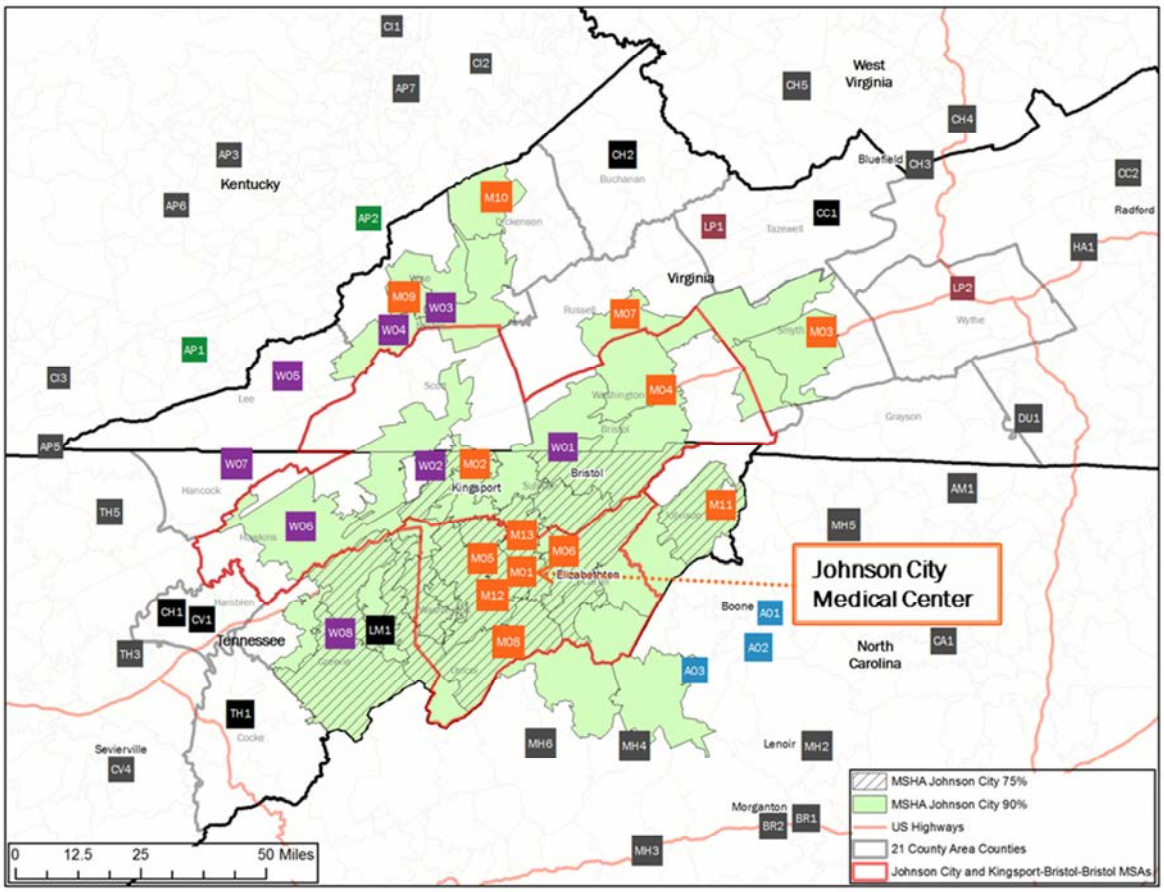
9. Indian Path Medical Center



Mountain States Indian Path Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	191	189	169	168
Licensed Beds	239	239	239	239
Staffed Beds Occupancy	40.9%	33.8%	39.5%	37.4%
Licensed Beds Occupancy	32.7%	26.7%	27.9%	26.3%
Average Daily Census	78	64	67	63
Patient Days	28,532	23,303	24,432	22,907
Discharges/Admissions	6,549	6,149	6,146	5,877
Average Length of Stay	4.4	3.8	4.0	3.9

Source: Tennessee Joint Annual Reports FY10-FY13

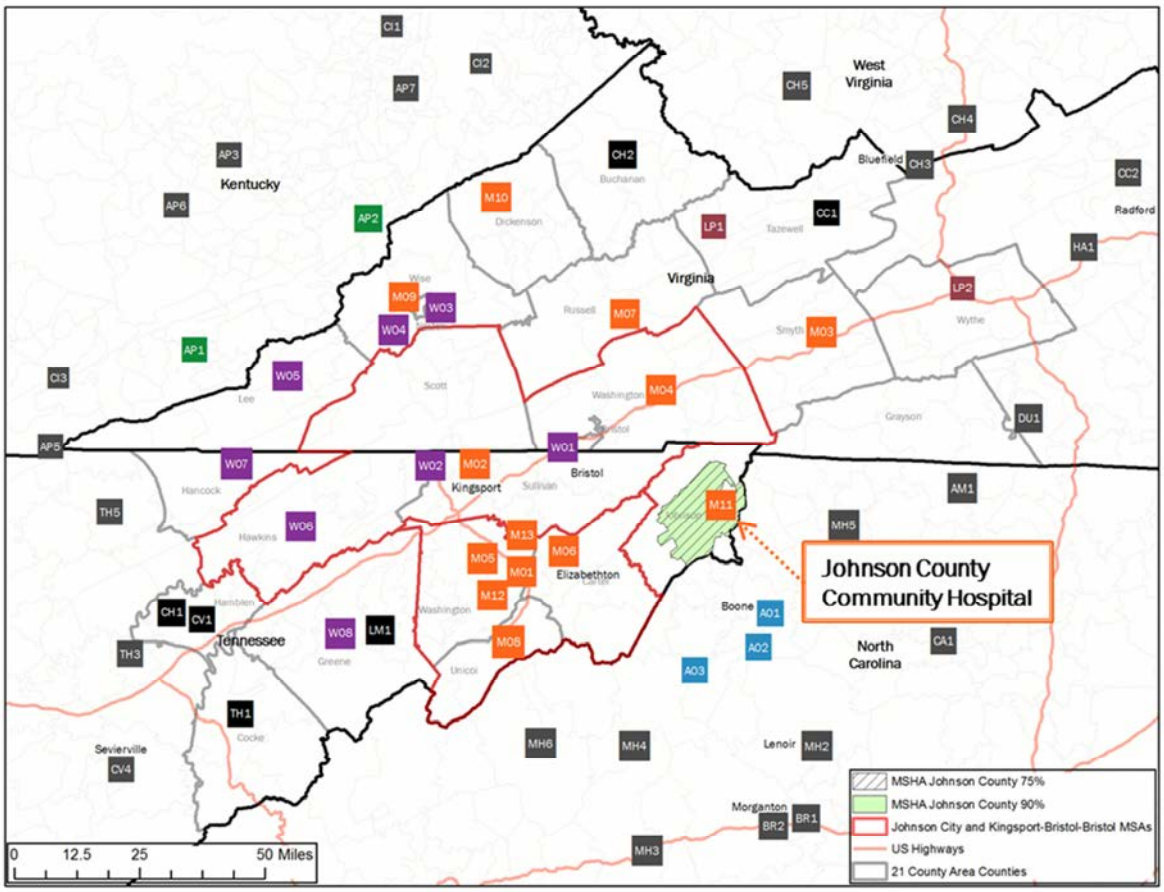
10. Johnson City Medical Center



Mountain States Johnson City Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	501	501	501	497
Licensed Beds	501	501	501	501
Staffed Beds Occupancy	75.8%	72.8%	72.4%	69.3%
Licensed Beds Occupancy	75.8%	72.8%	72.4%	68.7%
Average Daily Census	380	365	363	344
Patient Days	138,664	133,172	132,677	125,692
Discharges/Admissions	27,129	26,103	25,751	23,644
Average Length of Stay	5.1	5.1	5.2	5.3

Source: Tennessee Joint Annual Reports FY10-FY13

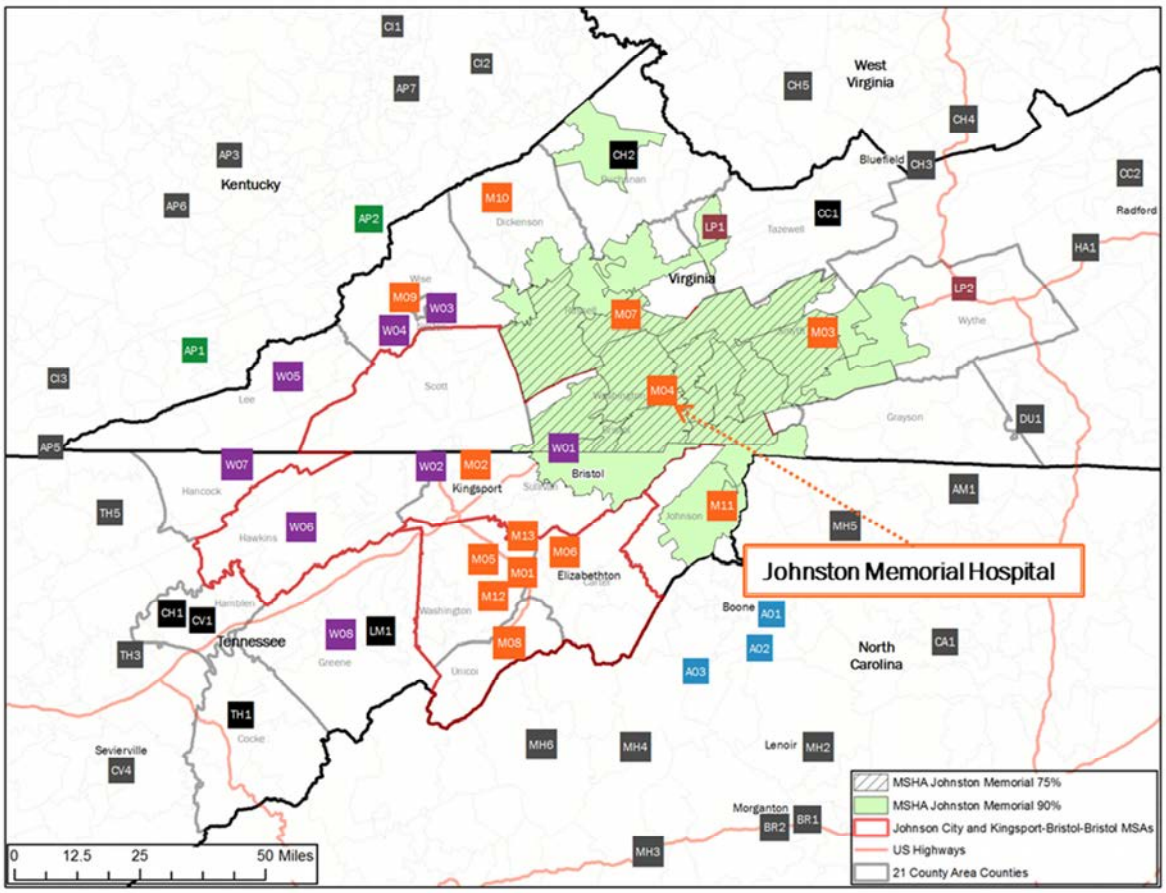
11. Johnson County Community Hospital



Mountain States Johnson County Community Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	2	2	2	2
Licensed Beds	2	2	2	2
Staffed Beds Occupancy	9.5%	5.9%	7.2%	6.0%
Licensed Beds Occupancy	9.5%	5.9%	7.2%	6.0%
Average Daily Census	0	0	0	0
Patient Days	69	43	53	44
Discharges/Admissions	29	20	26	23
Average Length of Stay	2.4	2.2	2.0	1.9

Source: Tennessee Joint Annual Reports FY10-FY13

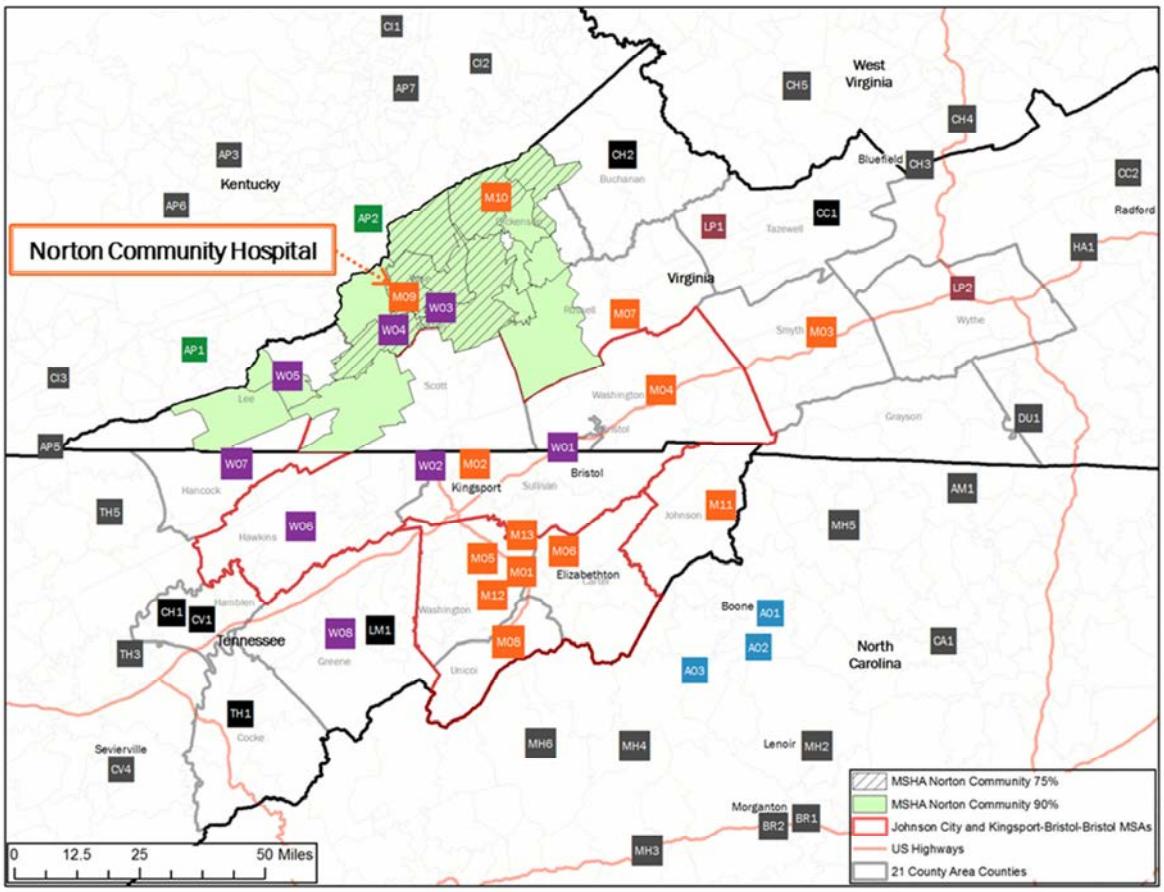
12. Johnston Memorial Hospital



Mountain States Johnston Memorial Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	100	116	116	112
Licensed Beds	135	116	116	116
Staffed Beds Occupancy	61.4%	51.6%	60.1%	58.3%
Licensed Beds Occupancy	45.5%	51.6%	60.1%	56.3%
Average Daily Census	61	60	70	65
Patient Days	22,427	21,866	25,511	23,822
Discharges/Admissions	5,883	6,156	7,053	7,215
Average Length of Stay	3.8	3.6	3.6	3.3

Source: Virginia Health Information Reports FY10-FY13

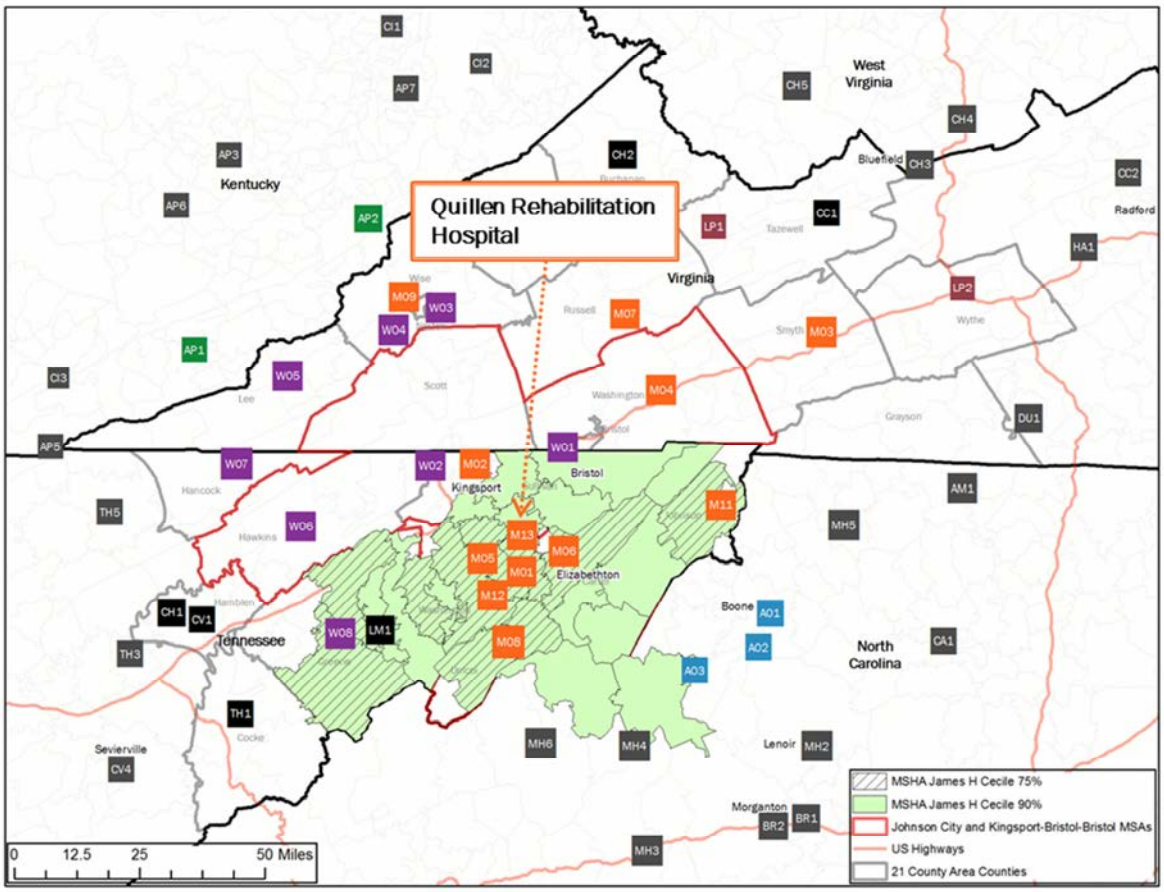
13. Norton Community Hospital



Mountain States Norton Community Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	40	40	50	50
Licensed Beds	129	129	129	129
Staffed Beds Occupancy	95.3%	94.9%	72.8%	70.5%
Licensed Beds Occupancy	29.6%	29.4%	28.2%	27.3%
Average Daily Census	38	38	36	35
Patient Days	13,916	13,858	13,320	12,859
Discharges/Admissions	4,308	4,375	4,149	3,685
Average Length of Stay	3.2	3.2	3.2	3.5

Source: Virginia Health Information Reports FY10-FY13

14. Quillen Rehabilitation Hospital

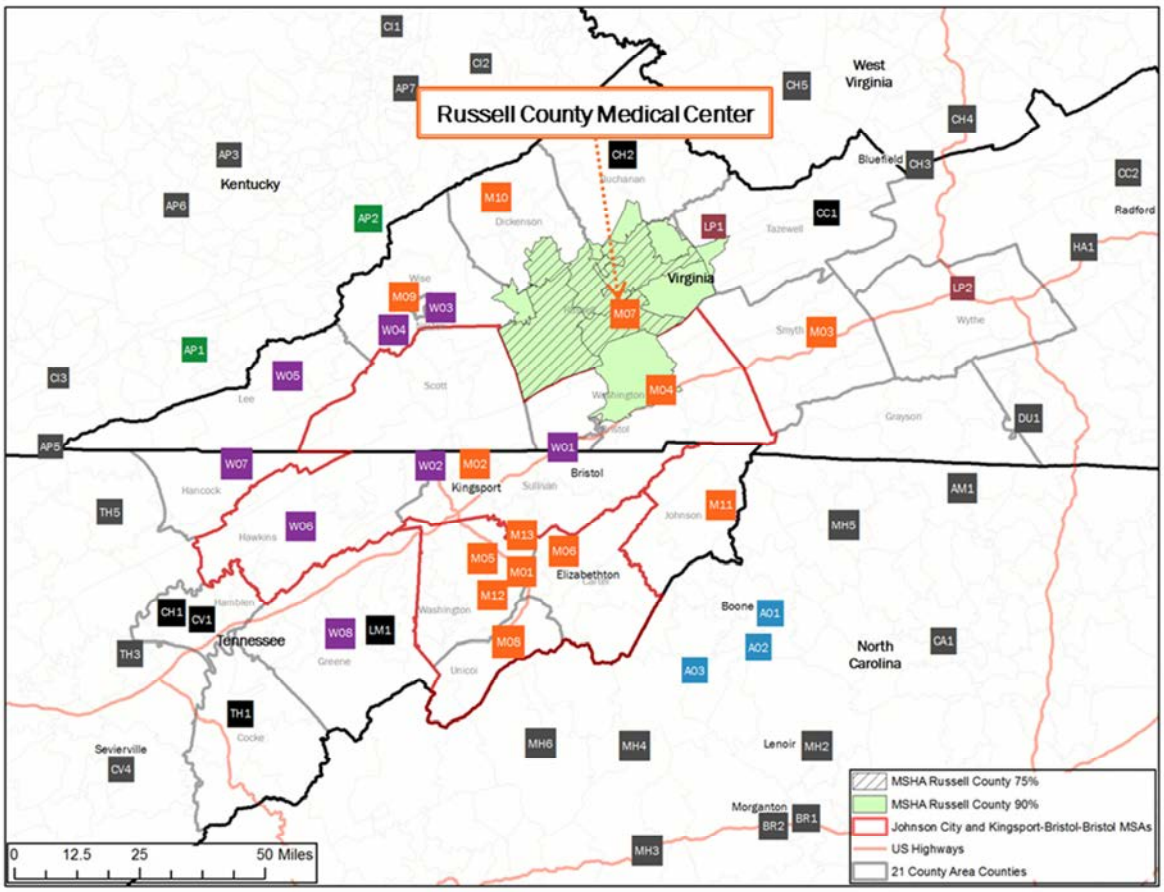


Mountain States James H. and Cecile C. Quillen Rehab Hospital Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds*	60	60	26	26
Licensed Beds	47	47	26	26
Staffed Beds Occupancy	45.3%	38.6%	81.0%	77.8%
Licensed Beds Occupancy	57.8%	49.3%	81.0%	77.8%
Average Daily Census	27	23	21	20
Patient Days	9,923	8,453	7,705	7,384
Discharges/Admissions	691	17,155	606	569
Average Length of Stay	14.4	12.9	12.7	13.0

*In FY10 and FY11, the number of staffed beds exceeds licensed beds because staffed beds include 13 separately licensed SNF beds co-located at Quillen Rehab Hospital.

Source: Tennessee Joint Annual Reports FY10-FY13

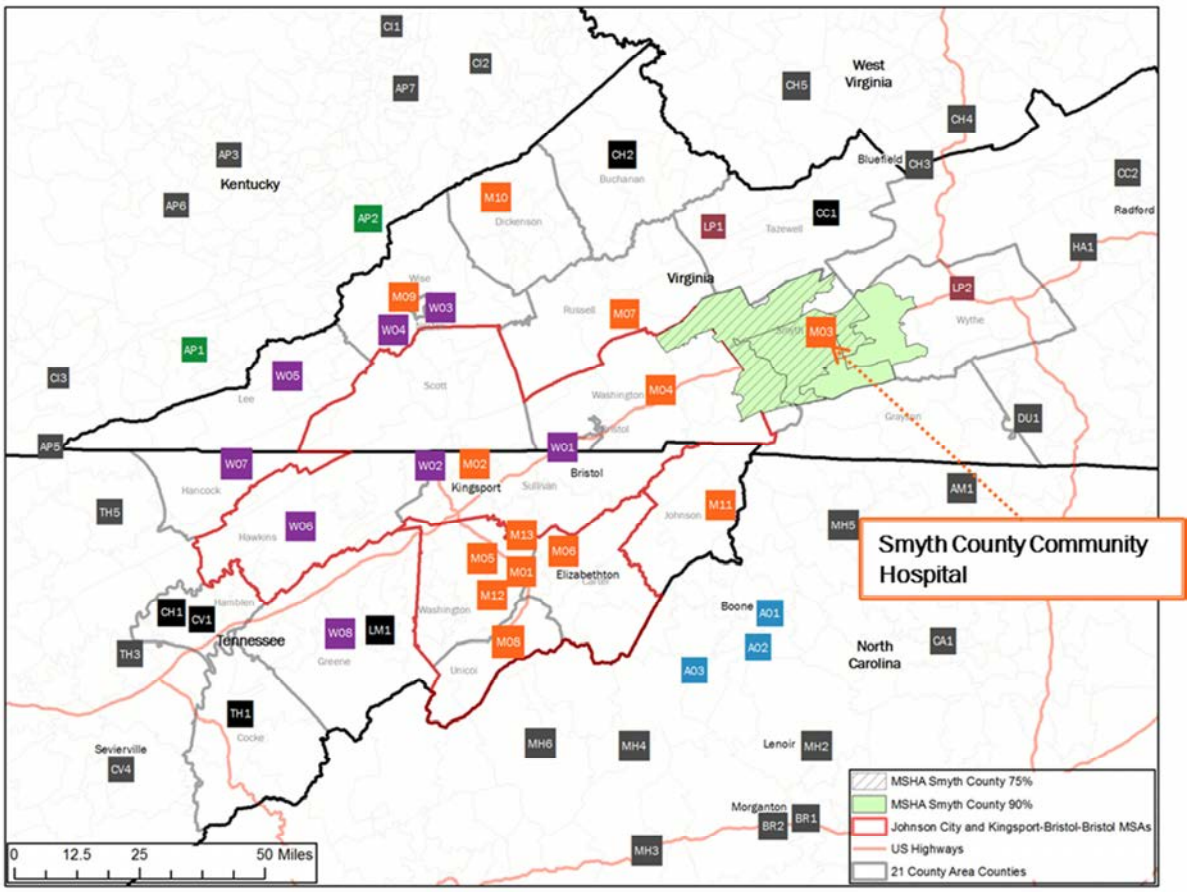
15. Russell County Medical Center



Mountain States Russell County Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	78	78	78	49
Licensed Beds	78	78	78	78
Staffed Beds Occupancy	44.9%	45.7%	43.3%	58.5%
Licensed Beds Occupancy	44.9%	45.7%	43.3%	36.7%
Average Daily Census	35	36	34	29
Patient Days	12,789	13,010	12,371	10,461
Discharges/Admissions	3,117	3,061	2,869	2,464
Average Length of Stay	4.1	4.3	4.3	4.2

Source: Virginia Health Information Reports FY10-FY13

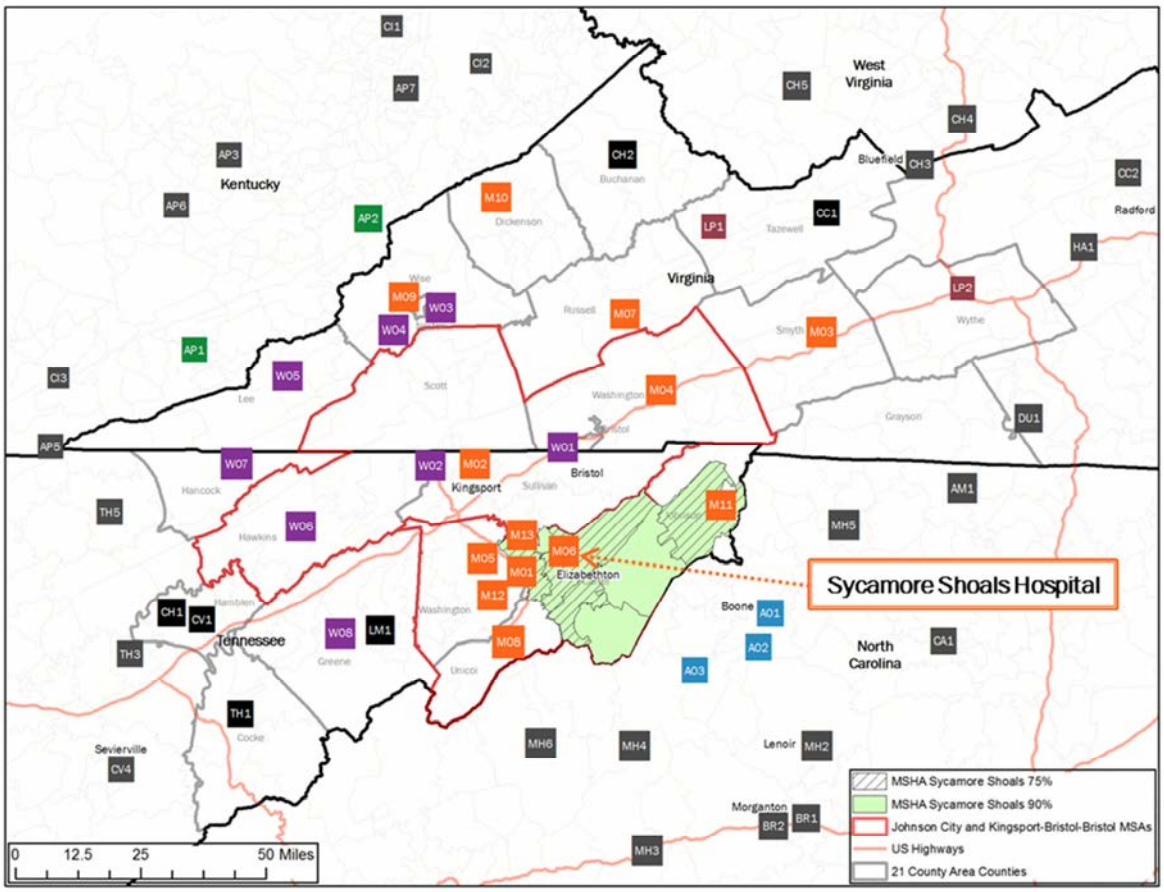
16. Smyth County Community Hospital



Mountain States Smyth County Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	54	44	44	44
Licensed Beds	170	170	139	44
Staffed Beds Occupancy	43.5%	51.3%	49.4%	48.1%
Licensed Beds Occupancy	13.8%	13.3%	15.6%	48.1%
Average Daily Census	23	23	22	21
Patient Days	8,569	8,234	7,951	7,729
Discharges/Admissions	2,498	2,275	1,962	1,713
Average Length of Stay	3.4	3.6	4.1	4.5

Source: Virginia Health Information Reports FY10-FY13

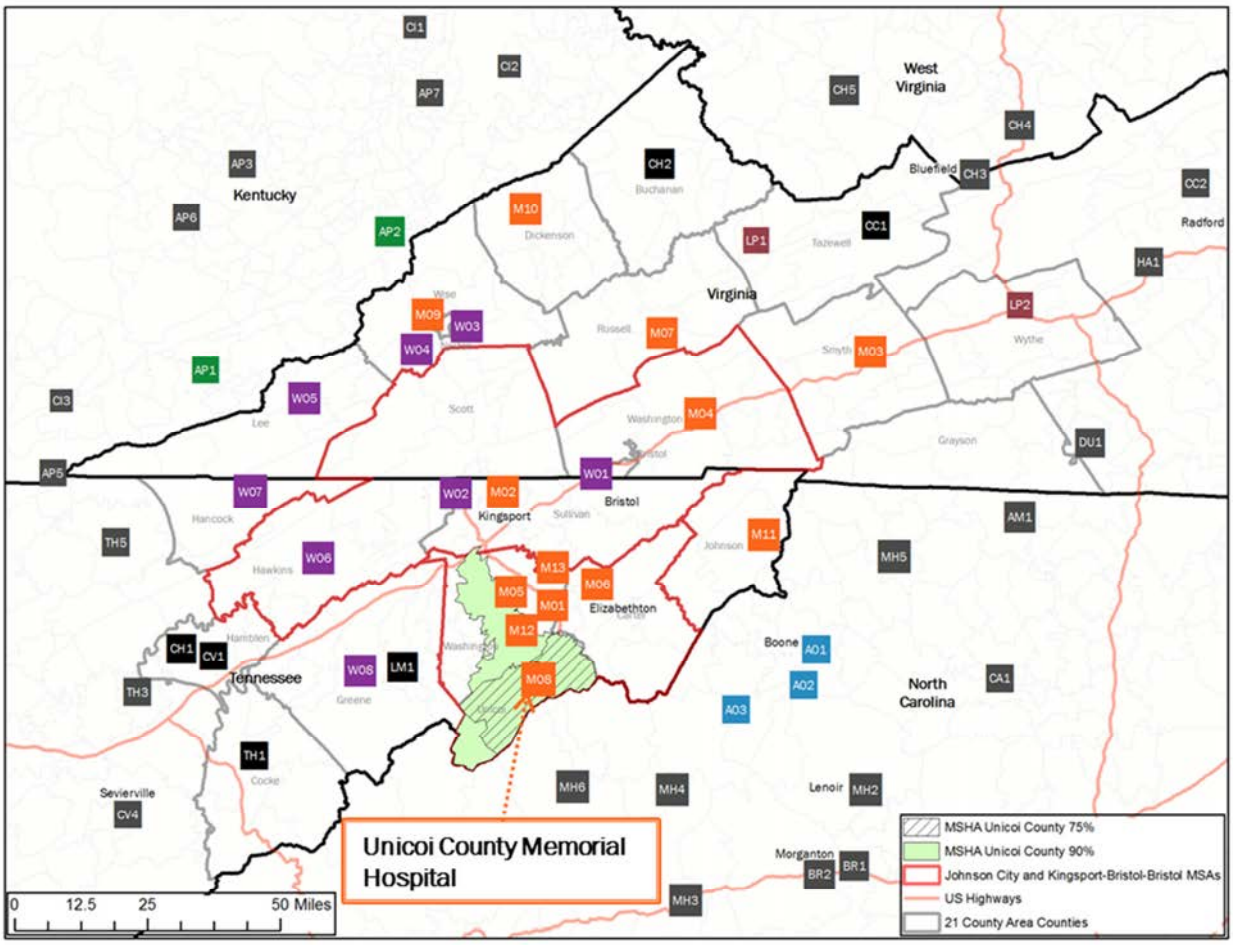
17. Sycamore Shoals Hospital



Mountain States Sycamore Shoals Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	79	79	79	74
Licensed Beds	121	121	121	121
Staffed Beds Occupancy	53.2%	53.1%	52.6%	57.0%
Licensed Beds Occupancy	34.7%	34.7%	34.3%	34.9%
Average Daily Census	42	42	42	42
Patient Days	15,334	15,299	15,206	15,398
Discharges/Admissions	3,448	3,640	3,673	3,430
Average Length of Stay	4.4	4.2	4.1	4.5

Source: Tennessee Joint Annual Reports FY10-FY13

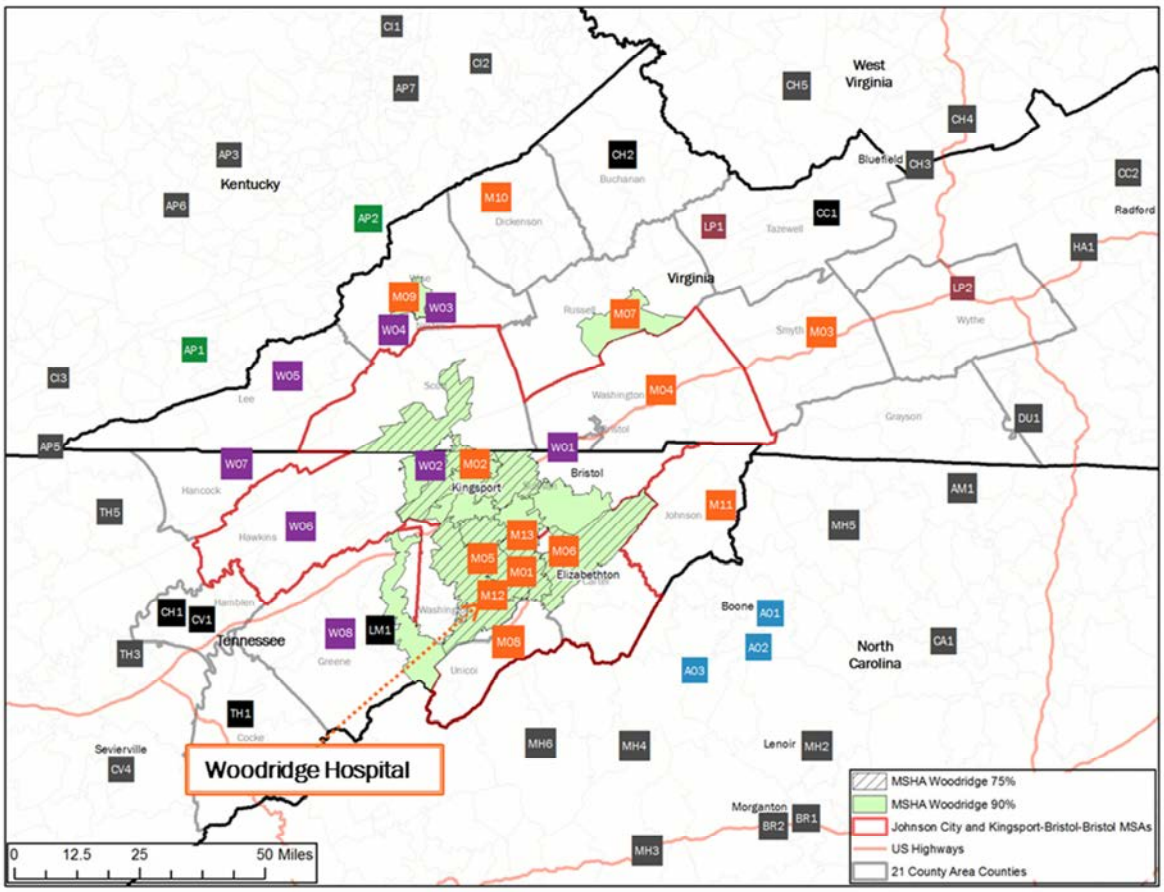
18. Unicoi County Memorial Hospital



Mountain States Unicoi County Comparative Statistics	FY2010	FY2011	FY2012	FY2013
Staffed Beds	25	10	7	7
Licensed Beds	48	48	48	48
Staffed Beds Occupancy	49.3%	126.6%	166.4%	169.7%
Licensed Beds Occupancy	25.7%	26.4%	24.3%	24.7%
Average Daily Census	12	13	12	12
Patient Days	4,499	4,622	4,262	4,336
Discharges/Admissions	1,223	1,221	1,098	1,060
Average Length of Stay	3.7	3.8	3.9	4.1

Source: Tennessee Joint Annual Reports FY10-FY13

19. Woodridge Hospital



Mountain States Woodridge Psychiatric Comparative Statistics				
	FY2010	FY2011	FY2012	FY2013
Staffed Beds	84	84	84	80
Licensed Beds	84	84	84	84
Staffed Beds Occupancy	63.8%	64.7%	69.4%	76.0%
Licensed Beds Occupancy	63.8%	64.7%	69.4%	72.4%
Average Daily Census	54	54	58	61
Patient Days	19,572	19,827	21,329	22,182
Discharges/Admissions	3,310	3,412	3,573	3,824
Average Length of Stay	5.9	5.8	6.0	5.8

Source: Tennessee Joint Annual Reports FY10-FY13

C. Geographic Service Area Payer Mix

For all discharges among residents living in the Geographic Service Area, payer mix was calculated from the 2014 inpatient discharge data.

Payer Class	Discharges	% of Discharges
Charity	1,328	1.1%
Commercial	21,027	17.5%
Government	1,142	0.9%
Medicaid	20,439	17.0%
Medicare	46,396	38.6%
Medicare HMO	17,726	14.7%
Missing	23	0.0%
Other	4,454	3.7%
Self Pay	7,495	6.2%
Worker's Comp	297	0.2%

Exhibit 5.2

Shares of the Geographic Service Area for general acute care inpatient services were calculated using Calendar Year 2014 discharge data for all Tennessee and Virginia hospitals using the Tennessee Hospital Discharge Data System and the Virginia Health Information's patient level database system.

A list of hospitals physically located in the Geographic Service Area is provided below. In addition, the table lists the top ten (10) out-of-area hospitals that serve patients in the Geographic Service Area.

Hospital Name	City	State
Wellmont Health System		
Wellmont Hancock County Hospital	Sneedville	TN
Wellmont Hawkins County Memorial Hospital	Rogersville	TN
Mountain View Regional Medical Center	Norton	VA
Wellmont Lonesome Pine Hospital	Big Stone Gap	VA
Wellmont Bristol Regional Medical Center	Bristol	TN
Wellmont Holston Valley Medical Center	Kingsport	TN
Mountain State Health Alliance		
Dickenson Community Hospital	Clintwood	VA
Johnson County Community Hospital	Mountain City	TN
Quillen Rehabilitation Hospital	Johnson City	TN
Unicoi County Memorial Hospital, Inc.	Erwin	TN
Smyth County Community Hospital	Marion	VA
Russell County Medical Center	Lebanon	VA
Norton Community Hospital	Norton	VA
Sycamore Shoals Hospital	Elizabethton	TN
Woodridge Psychiatric Hospital	Johnson City	TN
Franklin Woods Community Hospital	Johnson City	TN
Indian Path Medical Center	Kingsport	TN
Johnston Memorial Hospital	Abingdon	VA
Johnson City Medical Center	Johnson City	TN
Other Hospitals in the Geographic Service Area		
Takoma Regional Hospital	Greeneville	TN
Carilion Tazewell Community Hospital	Tazewell	VA
Buchanan General Hospital	Grundy	VA
Wythe County Community Hospital	Wytheville	VA
Tennova Healthcare-Lakeway Regional Hospital	Morristown	TN
Tennova Healthcare-Newport Medical Center	Newport	TN
Laughlin Memorial Hospital, Inc.	Greeneville	TN
Clinch Valley Medical Center	Richlands	VA
Morristown-Hamblen Healthcare System	Morristown	TN
Top 10 Hospitals Outside Geographic Service Area Serving Geographic Service Area Patients		
University Of Tennessee Medical Center	Knoxville	TN
Carilion Medical Center	Dayton	VA
Tennova Healthcare-Physicians Regional Medical Center	Knoxville	TN

Hospital Name	City	State
Vanderbilt University Hospitals	Nashville	TN
University Of Virginia Medical Center	Charlottesville	VA
Fort Sanders Regional Medical Center	Knoxville	TN
Carilion New River Valley Medical Center	Christiansburg	VA
Peninsula Hospital	Louisville	TN
East Tennessee Children's Hospital	Knoxville	TN
Twin County Regional Hospital	Galax	VA

Below are the aggregated system shares for Mountain States, Wellmont, and both combined. These shares are based on the hospital discharges including MDCs 19 and 20.

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

System	Total	Share of Total Discharges
New Health System	93,516	73.0%
Independent Competition	34,584	27.0%

In the two tables below, Wellmont hospitals are highlighted in blue and Mountain States hospitals are highlighted in green. There are a number of independent hospitals located in the Geographic Service Area and these are highlighted in orange. There are a number of hospitals located outside of the Geographic Service Area used by patients in the area; the top several of these hospitals are shown (without highlighting).

Hospital and health system shares were calculated using a denominator of the total number of discharges of residents in the Geographic Service Area. An individual hospital's share is its total discharges of residents from the Geographic Service Area divided by the total number of area discharges. Health system shares are calculated as the sum of all of its hospitals' shares.

To estimate the share that a given Wellmont (Mountain States) hospital accounts for of the combined system share, its total discharges are shown as a percentage of the combined systems' discharges. These percentages are shown in the column labeled Shares of Wellmont and Mountain States Discharges.

Shares were calculated for general acute care services excluding normal newborns (DRG 795) and including/excluding MDC 19 and 20 and for all payers.

A. Inpatient (Including MDCs 19 and 20)

Hospital Name	Hospital Affiliation	Total	Shares of Total Discharges	Shares of Wellmont and Mountain States Discharges
Total		**128,100**	**100.0%**	
Total GSA Hospitals		**115,691**	**90.3%**	
Total Non-GSA Hospitals		**12,409**	**9.7%**	
Share Outside GSA		**9.7%**		
WELLMONT HANCOCK COUNTY HOSPITAL	Wellmont	181	0.1%	0.2%
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	Wellmont	1,025	0.8%	1.1%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	Wellmont	1,168	0.9%	1.2%
WELLMONT LONESOME PINE HOSPITAL	Wellmont	1,712	1.3%	1.8%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	Wellmont	14,158	11.1%	15.1%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	Wellmont	16,831	13.1%	18.0%
DICKENSON COMMUNITY HOSPITAL	Mountain States	5	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	Mountain States	14	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	Mountain States	491	0.4%	0.5%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	Mountain States	760	0.6%	0.8%
SMYTH COUNTY COMMUNITY HOSPITAL	Mountain States	1,779	1.4%	1.9%
RUSSELL COUNTY MEDICAL CENTER	Mountain States	1,957	1.5%	2.1%
NORTON COMMUNITY HOSPITAL	Mountain States	3,132	2.4%	3.3%
SYCAMORE SHOALS HOSPITAL	Mountain States	3,438	2.7%	3.7%
WOODRIDGE PSYCHIATRIC HOSPITAL	Mountain States	4,337	3.4%	4.6%
FRANKLIN WOODS COMMUNITY HOSPITAL	Mountain States	5,160	4.0%	5.5%
INDIAN PATH MEDICAL CENTER	Mountain States	5,972	4.7%	6.4%
JOHNSTON MEMORIAL HOSPITAL	Mountain States	8,182	6.4%	8.7%
JOHNSON CITY MEDICAL CENTER	Mountain States	23,214	18.1%	24.8%
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	546	0.4%	
BUCHANAN GENERAL HOSPITAL	Other	1,048	0.8%	
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,809	1.4%	
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,830	1.4%	
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,028	1.6%	
TAKOMA REGIONAL HOSPITAL	Other	2,452	1.9%	
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,230	2.5%	
CLINCH VALLEY MEDICAL CENTER	Other	4,131	3.2%	
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	Other	5,101	4.0%	
UNIVERSITY OF TENNESSEE MEDICAL CENTER	Other	1,766	1.4%	
CARILION MEDICAL CENTER	Other	1,228	1.0%	
TENNOVA HEALTHCARE-PHYSICIANS REGIONAL	Other	1,047	0.8%	
VANDERBILT UNIVERSITY HOSPITALS	Other	874	0.7%	
UNIVERSITY OF VIRGINIA MEDICAL CENTER	Other	869	0.7%	
All Other		6,625	5.2%	

B. Inpatient (Excluding MDCs 19 and 20)

Hospital Name	Hospital Affiliation	Total	Shares of Total Discharges	Shares of Wellmont and Mountain States Discharges
Total		**119,282**	**100.0%**	
Total GSA Hospitals		**108,392**	**90.9%**	
Total Non-GSA Hospitals		**10,890**	**9.1%**	
Share Outside GSA		**9.1%**		
WELLMONT HANCOCK COUNTY HOSPITAL	Wellmont	179	0.2%	0.2%
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	Wellmont	1,012	0.8%	1.2%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	Wellmont	1,160	1.0%	1.3%
WELLMONT LONESOME PINE HOSPITAL	Wellmont	1,704	1.4%	2.0%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	Wellmont	13,000	10.9%	15.0%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	Wellmont	16,773	14.1%	19.4%
DICKENSON COMMUNITY HOSPITAL	Mountain States	5	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	Mountain States	14	0.0%	0.0%
WOODRIDGE PSYCHIATRIC HOSPITAL	Mountain States	32	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	Mountain States	491	0.4%	0.6%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	Mountain States	757	0.6%	0.9%
RUSSELL COUNTY MEDICAL CENTER	Mountain States	1,313	1.1%	1.5%
SMYTH COUNTY COMMUNITY HOSPITAL	Mountain States	1,753	1.5%	2.0%
NORTON COMMUNITY HOSPITAL	Mountain States	3,120	2.6%	3.6%
SYCAMORE SHOALS HOSPITAL	Mountain States	3,167	2.7%	3.7%
FRANKLIN WOODS COMMUNITY HOSPITAL	Mountain States	5,138	4.3%	5.9%
INDIAN PATH MEDICAL CENTER	Mountain States	5,939	5.0%	6.9%
JOHNSTON MEMORIAL HOSPITAL	Mountain States	8,123	6.8%	9.4%
JOHNSON CITY MEDICAL CENTER	Mountain States	22,983	19.3%	26.5%
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	543	0.5%	
BUCHANAN GENERAL HOSPITAL	Other	1,041	0.9%	
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,801	1.5%	
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,820	1.5%	
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,011	1.7%	
TAKOMA REGIONAL HOSPITAL	Other	2,270	1.9%	
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,225	2.7%	
CLINCH VALLEY MEDICAL CENTER	Other	4,102	3.4%	
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	Other	4,916	4.1%	
UNIVERSITY OF TENNESSEE MEDICAL CENTER	Other	1,764	1.5%	
CARILION MEDICAL CENTER	Other	1,159	1.0%	
TENNOVA HEALTHCARE-PHYSICIANS REGIONAL	Other	1,045	0.9%	
UNIVERSITY OF VIRGINIA MEDICAL CENTER	Other	862	0.7%	
VANDERBILT UNIVERSITY HOSPITALS	Other	856	0.7%	
All Other		5,204	4.4%	

Exhibit 6.1

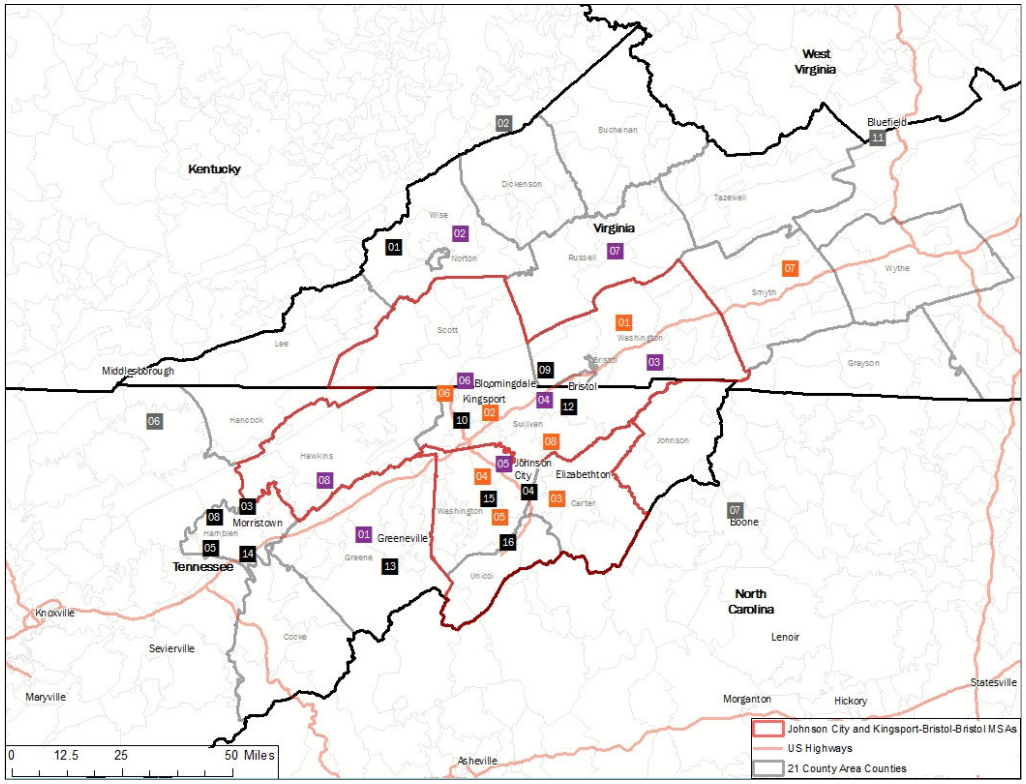
Outpatient analyses for the Geographic Service Area were conducted using counts of facilities for a variety of types of outpatient providers serving the area; these include out-of-area facilities. Facility-level data included the name, address, affiliation and type of service (e.g., ASC). A summary table for all categories of outpatient services is provided below and shows that for many services there is little or no overlap and that for the majority of services, independent providers account for a large share of total providers. In the few services in which there is higher share, there is no overlap. More detailed analyses were also conducted for three outpatient categories: urgent care, imaging facilities, and ambulatory surgery centers; and the tables below show that competing facilities account for 50% or greater share for each of these services. Maps show that these alternatives are located near those affiliated with Mountain States and Wellmont.

A. All Outpatient Facilities

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

*All Other may include competing facilities located outside of the Geographic Service Area yet serving patients from the Geographic Service Area.

B. Urgent Care



Urgent Care Outpatient Facilities

Wellmont

01	Greeneville Urgent Care
02	Wellmont Extended Hours Clinic - Norton
03	Wellmont Urgent Care - Abingdon
04	Wellmont Urgent Care - Bristol
05	Wellmont Urgent Care - Johnson City
06	Wellmont Urgent Care - Kingsport
07	Wellmont Urgent Care - Lebanon
08	Wellmont Urgent Care - Rogersville

MSHA

01	First Assist Urgent Care - Abingdon
02	First Assist Urgent Care - Colonial Heights
03	First Assist Urgent Care - Elizabethton
04	First Assist Urgent Care - Johnson City
05	First Assist Urgent Care - Jonesborough
06	First Assist Urgent Care - Kingsport
07	First Assist Urgent Care - Marion
08	First Assist Urgent Care - Piney Flats

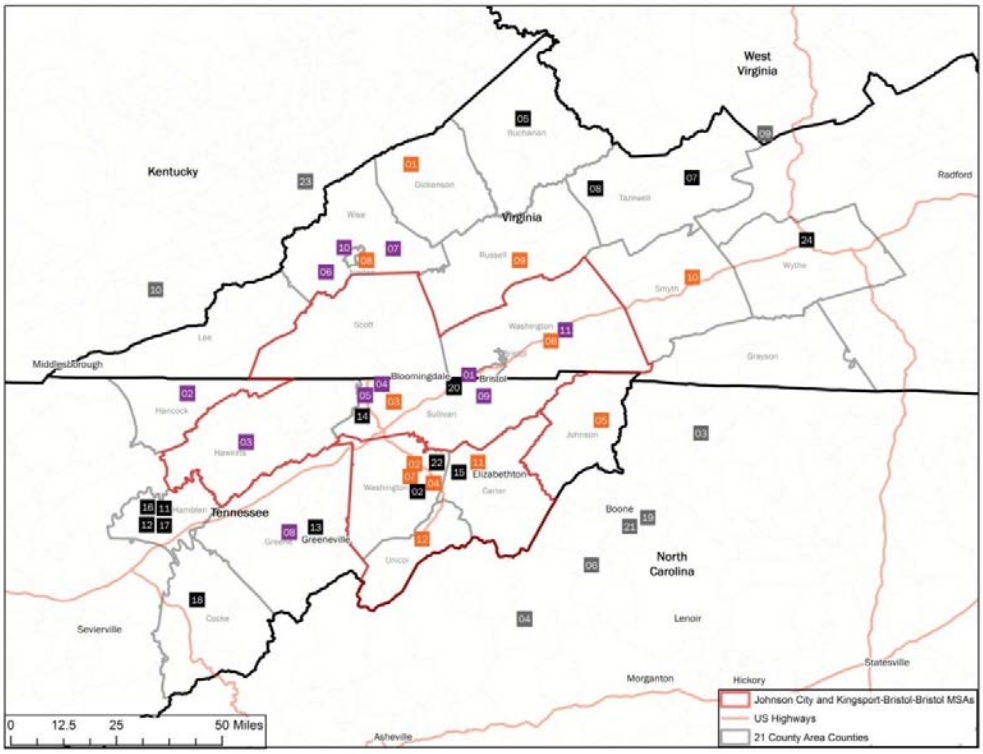
All Other Facilities

01	Appalachian After Hours Care
02	AppUrgent Care
03	College Park Medical Clinic
04	Doctors Care
05	Express Health Clinic-Morristown
06	Express Health Clinic-Newport
07	FastMed Urgent Care
08	HealthStar Urgent Care Clinic
09	Holston Medical Group Urgent Care-Bristol
10	Holston Medical Group Urgent Care-Kingsport
11	MedExpress Urgent Care-Bluefield
12	MedExpress Urgent Care-Bristol
13	Patmos EmergiClinic
14	Prompt Family Care
15	State of Franklin Healthcare Associates Walk-in Clinic
16	Urgent Care of Erwin

Urgent Care Facility Locations and Counts, by System

Affiliation	Facility Name	County	State
Total	**Total**	**32**	**100.0%**
Wellmont	Greeneville Urgent Care	Greene	TN
Wellmont	Wellmont Extended Hours Clinic - Norton	Wise	VA
Wellmont	Wellmont Urgent Care - Abingdon	Washington	VA
Wellmont	Wellmont Urgent Care - Bristol	Sullivan	TN
Wellmont	Wellmont Urgent Care - Johnson City	Washington	TN
Wellmont	Wellmont Urgent Care - Kingsport	Sullivan	TN
Wellmont	Wellmont Urgent Care - Lebanon	Russell	VA
Wellmont	Wellmont Urgent Care - Rogersville	Rogersville	TN
Wellmont	**Total**	**8**	**25%**
Mountain States	First Assist Urgent Care - Abingdon	Washington	VA
Mountain States	First Assist Urgent Care - Colonial Heights	Sullivan	TN
Mountain States	First Assist Urgent Care - Elizabethton	Carter	TN
Mountain States	First Assist Urgent Care - Johnson City	Washington	TN
Mountain States	First Assist Urgent Care - Jonesborough	Washington	TN
Mountain States	First Assist Urgent Care - Kingsport	Sullivan	TN
Mountain States	First Assist Urgent Care - Marion	Smyth	VA
Mountain States	First Assist Urgent Care - Piney Flats	Washington	TN
Mountain States	**Total**	**8**	**25%**
All Other	AppUrgent Care	Watauga	NC
All Other	Appalachian After Hours Care	Wise	VA
All Other	College Park Medical Clinic	Hamblen	TN
All Other	Doctors Care	Washington	TN
All Other	Express Health Clinic-Morristown	Hamblen	TN
All Other	Express Health Clinic-Newport	Cocke	TN
All Other	FastMed Urgent Care	Watauga	NC
All Other	HealthStar Urgent Care Clinic	Hamblen	TN
All Other	Holston Medical Group Urgent Care-Bristol	Sullivan	TN
All Other	Holston Medical Group Urgent Care-Kingsport	Sullivan	TN
All Other	MedExpress Urgent Care-Bluefield	Tazewell	VA
All Other	MedExpress Urgent Care-Bristol	Sullivan	TN
All Other	Patmos EmergiClinic	Greene	TN
All Other	Prompt Family Care	Hamblen	TN
All Other	State of Franklin Healthcare Associates Walk-in Clinic	Washington	TN
All Other	Urgent Care of Erwin	Unicoi	TN
All Other	**Total**	**16**	**50%**

C. CT/MRI



CT/MRI Capabilities

	Wellmont
01	Bristol Regional Medical Center
02	Hancock County Hospital
03	Hawkins County Memorial Hospital
04	Holston Valley Imaging Center, LLC
05	Holston Valley Medical Center
06	Lonesome Pine Hospital
07	Southwest Virginia Cancer Center
08	Takoma Regional Hospital *(Independent)**
09	Volunteer Parkway Imaging Center
10	Wellmont Mountain View Regional Medical Center
11	Wellmont Urgent Care Abingdon

	MSHA
01	Dickenson Community Hospital
02	Franklin Woods Community Hospital
03	Indian Path Medical Center
04	Johnson City Medical Center
05	Johnson County Community Hospital
06	Johnston Memorial Hospital
07	Mountain States Imaging at Med Tech Parkway
08	Norton Community Hospital
09	Russell County Medical Center
10	Smyth County Community Hospital
11	Sycamore Shoals Hospital
12	Unicoi County Memorial Hospital, Inc.

	All Other Facilities
01	Appalachian Orthopaedic Associates, PC**
02	Appalachian Orthopaedic Associates
03	Ashe Memorial Hospital
04	Blue Ridge Regional Hospital
05	Buchanan General Hospital
06	Cannon Memorial Hospital
07	Carilion Tazewell Community Hospital
08	Clinch Valley Medical Center
09	Community Radiology Of Virginia, Inc.
10	Harlan ARH Hospital
11	Healthstar Physicians, PC
12	Lakeway Regional Hospital
13	Laughlin Memorial Hospital, Inc.
14	Meadowview Outpatient Diagnostic Center
15	Medical Care, PLLC (Elizabethton)
16	Medical Care, PLLC (Johnson City)
17	Morristown-Hamblen Hospital
18	Newport Medical Center
19	Ortho-Carolina - Boone
20	Sapling Grove Outpatient Diagnostic Center
21	Watauga Medical Center
22	Watauga Orthopaedics, PLC
23	Whitesburg ARH Hospital
24	Wythe County Community Hospital

* Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

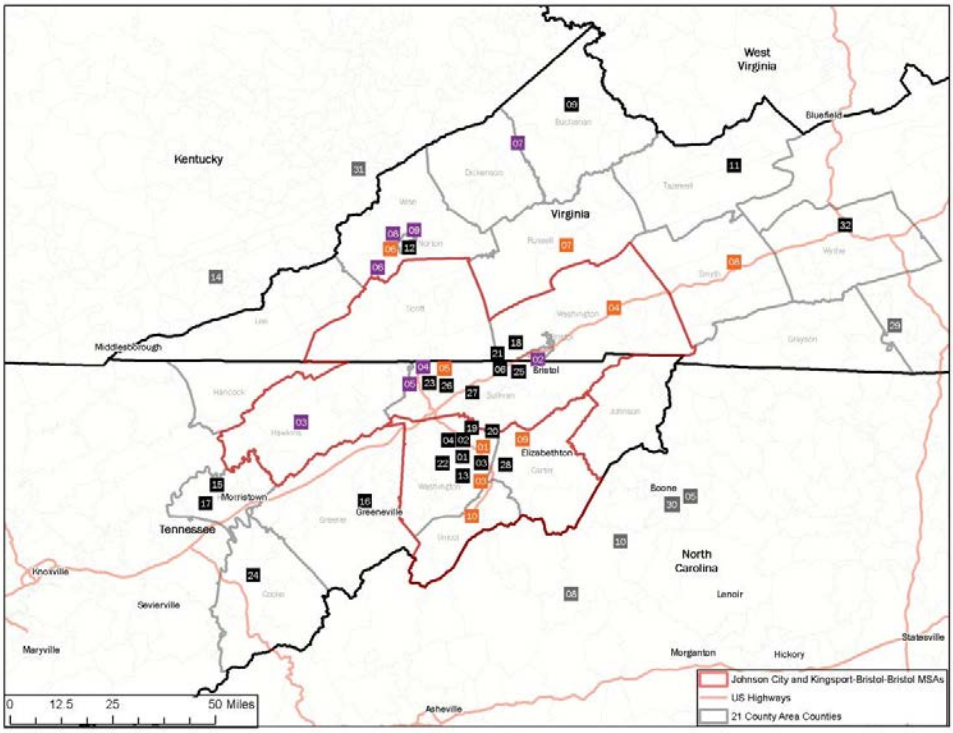
** Appalachian Orthopaedic Associates, PC is co-located with Bristol Regional Medical Center and is therefore not visible on the map

Imaging Capabilities Locations and Counts, by System

System Affiliation	Facility Name	County	State	CT Capabilities	MRI Capabilities
Total	**Total**	**47**	**100%**	**43**	**41**
Wellmont	Bristol Regional Medical Center	Sullivan	TN	X	X
Wellmont	Hancock County Hospital	Hancock	TN	X	
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN	X	X
Wellmont	Holston Valley Imaging Center, LLC	Sullivan	TN	X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN	X	X
Wellmont	Lonesome Pine Hospital	Wise	VA	X	X
Wellmont	Southwest Virginia Cancer Center	Wise	VA	X	
Wellmont	Volunteer Parkway Imaging Center	Sullivan	TN	X	X
Wellmont	Wellmont Mountain View Regional Medical Center	Wise	VA	X	X
Wellmont	Wellmont Urgent Care Abingdon	Washington	VA	X	
Wellmont	**Total**	**10**	**21.3%**	**10**	**7**
Mountain States	Dickenson Community Hospital	Dickenson	VA	X	
Mountain States	Franklin Woods Community Hospital	Washington	TN	X	X
Mountain States	Indian Path Medical Center	Sullivan	TN	X	X
Mountain States	Johnson City Medical Center	Washington	TN	X	X
Mountain States	Johnson County Community Hospital	Johnson	TN	X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X
Mountain States	Mountain States Imaging at Med Tech Parkway	Washington	TN	X	X
Mountain States	Norton Community Hospital	Wise	VA	X	X
Mountain States	Russell County Medical Center	Russell	VA	X	X
Mountain States	Smyth County Community Hospital	Smyth	VA	X	X
Mountain States	Sycamore Shoals Hospital	Carter	TN	X	X
Mountain States	Unicoi County Memorial Hospital, Inc.	Unicoi	TN	X	X
Mountain States	**Total**	**12**	**25.5%**	**12**	**11**
All Other	Appalachian Orthopaedic Associates, PC	Sullivan	TN		X
All Other	Appalachian Orthopaedic Associates	Washington	TN		X
All Other	Ashe Memorial Hospital	Ashe	NC	X	X
All Other	Blue Ridge Regional Hospital	Mitchell	NC	X	X
All Other	Buchanan General Hospital	Buchanan	VA	X	X
All Other	Cannon Memorial Hospital	Avery	NC	X	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA	X	X
All Other	Clinch Valley Medical Center	Tazewell	VA	X	X
All Other	Community Radiology Of Virginia, Inc.	Tazewell	VA	X	X
All Other	Harlan ARH Hospital	Harlan	KY	X	X
All Other	Healthstar Physicians, PC	Hamblen	TN	X	X
All Other	Lakeway Regional Hospital	Hamblen	TN	X	X

System Affiliation	Facility Name	County	State	CT Capabilities	MRI Capabilities
All Other	Laughlin Memorial Hospital, Inc.	Greene	TN	X	X
All Other	Meadowview Outpatient Diagnostic Center	Sullivan	TN	X	X
All Other	Medical Care, PLLC (Elizabethton)	Carter	TN	X	
All Other	Medical Care, PLLC (Johnson City)	Washington	TN	X	
All Other	Morristown-Hamblen Hospital	Hamblen	TN	X	X
All Other	Newport Medical Center	Cocke	TN	X	X
All Other	Ortho-Carolina - Boone	Watauga	NC		X
All Other	Sapling Grove Outpatient Diagnostic Center	Sullivan	TN	X	X
All Other	Takoma Regional Hospital	Greene	TN	X	X
All Other	Watauga Medical Center	Watauga	NC	X	X
All Other	Watauga Orthopaedics, PLC	Washington	TN		X
All Other	Whitesburg ARH Hospital	Letcher	KY	X	X
All Other	Wythe County Community Hospital	Wythe	VA	X	X
All Other	**Total**	**25**	**53.2%**	**21**	**23**

D. Ambulatory Surgical Centers[2]



Ambulatory Surgical Centers Outpatient Facilities

Wellmont

01	Bristol Regional Medical Center
02	Bristol Surgery Center
03	Hawkins County Memorial Hospital
04	Holston Valley Medical Center
05	Holston Valley Surgery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital *(Independent)**
09	Wellmont Mountain View Regional Medical

MSHA

01	Franklin Woods Community Hospital
02	Indian Path Medical Center
03	Johnson City Medical Center
04	Johnston Memorial Hospital
05	Kingsport Ambulatory Surgery Center**
06	Norton Community Hospital
07	Russell County Medical Center
08	Smyth County Community Hospital
09	Sycamore Shoals Hospital
10	Unicoi County Community Hospital

All Other Facilities

01	East Tennessee Ambulatory Surgery Center, LLC***
02	Johnson City Eye Surgery Center***
03	Mountain Empire Surgery Center, LP***
04	TriCities Laser Center***
05	Appalachian Gastroenterology
06	Appalachian Orthopaedic Associates, PC
07	Ashe Memorial Hospital
08	Blue Ridge Regional Hospital
09	Buchanan General Hospital
10	Cannon Memorial Hospital
11	Carilion Tazewell Community Hospital
12	Clinch Valley Medical Center
13	Endoscopy Center of Northeast Tennessee, PC
14	Harlan ARH Hospital
15	Lakeway Regional Hospital
16	Laughlin Memorial Hospital
17	Morristown-Hamblen Healthcare System
18	Mountain Empire Cataract and Eye Surgery Center
19	PMA Surgery Center, LLC
20	Reeves Eye Surgery Center
21	Renaissance Surgery Center
22	State of Frankin OB/GYN Specialists
23	Sullivan Digestive Center
24	Tennova Healthcare - Newport Medical Center
25	The Endoscopy Center of Bristol
26	The Regional Eye Surgery Center
27	Tri Cities Gastroenterology
28	Tri-Cities Outpatient Surgery, LLC
29	Twin County Regional Hospital
30	Watauga Medical Center
31	Whitesburg ARH Hospital
32	Wythe County Community Hospital

* Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

** Managed Joint Venture

*** Non-Managed Joint Venture

[2] ASCs include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities; these facilities are included in map and table.

Ambulatory Surgical Center Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Total	**Total**			**17**	**31**	**30**
Wellmont	Bristol Regional Medical Center	Sullivan	TN		X	X
Wellmont	Bristol Surgery Center	Sullivan	TN	X		
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN		X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN		X	X
Wellmont	Holston Valley Surgery Center, LLC	Sullivan	TN	X		
Wellmont	Lonesome Pine Hospital	Wise	VA		X	X
Wellmont	Sapling Grove ASC	Sullivan	TN	X		
Wellmont	Wellmont Mountain View Regional Medical	Wise	VA		X	X
Wellmont	**Total**			**3**	**5**	**5**
Mountain States	Franklin Woods Community Hospital	Washington	TN		X	X
Mountain States	Indian Path Medical Center	Sullivan	TN		X	X
Mountain States	Johnson City Medical Center	Washington	TN		X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X	X
Mountain States	Kingsport Ambulatory Surgery Center[3]	Sullivan	TN	X		
Mountain States	Norton Community Hospital	Wise	VA		X	X
Mountain States	Russell County Medical Center	Russell	VA		X	X
Mountain States	Smyth County Community Hospital	Smyth	VA		X	X
Mountain States	Sycamore Shoals Hospital	Carter	TN		X	X
Mountain States	Unicoi County Community Hospital	Unicoi	TN		X	X
Mountain States	**Total**			**2**	**9**	**9**
Non-Managed Joint Venture	East Tennessee Ambulatory Surgery Center, LLC	Washington	TN	X		
Non-Managed Joint Venture	Johnson City Eye Surgery Center	Washington	TN	X		
Non-Managed Joint Venture	Mountain Empire Surgery Center, LP	Washington	TN	X		

[3] Kingsport Ambulatory Surgery Center is a Managed Joint Venture.

Ambulatory Surgical Center Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Non-Managed Joint Venture	TriCities Laser Center	Washington	TN	X		
Non-Managed Joint Venture	**Total**			**4**	**0**	**0**
All Other	Appalachian Gastroenterology	Watauga	NC		X	
All Other	Ashe Memorial Hospital	Ashe	NC		X	X
All Other	Blue Ridge Regional Hospital	Mitchell	NC		X	X
All Other	Buchanan General Hospital	Buchanan	VA		X	X
All Other	Cannon Memorial Hospital	Avery	NC		X	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA			X
All Other	Clinch Valley Medical Center	Tazewell	VA		X	X
All Other	Endoscopy Center of Northeast Tennessee, PC	Washington	TN		X	
All Other	Harlan ARH Hospital	Harlan	KY		X	X
All Other	Lakeway Regional Hospital	Hamblen	TN		X	X
All Other	Laughlin Memorial Hospital	Greene	TN		X	X
All Other	Morristown-Hamblen Healthcare System	Hamblen	TN		X	X
All Other	Mountain Empire Cataract and Eye Surgery Center	Sullivan	TN	X		
All Other	PMA Surgery Center, LLC	Washington	TN	X		
All Other	Reeves Eye Surgery Center	Washington	TN	X		
All Other	Regional Surgical Services	Tazewell	VA	X		
All Other	Renaissance Surgery Center	Sullivan	TN	X		
All Other	State of Franklin OB/GYN Specialists	Washington	TN	X		
All Other	Sullivan Digestive Center	Sullivan	TN		X	
All Other	Takoma Regional Hospital	Greene	TN			X
All Other	Tennova Healthcare - Newport Medical Center	Cocke	TN		X	X
All Other	The Endoscopy Center of Bristol	Sullivan	TN		X	
All Other	The Regional Eye Surgery Center	Sullivan	TN	X		
All Other	Tri Cities Gastroenterology	Sullivan	TN		X	

Ambulatory Surgical Center Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
All Other	Tri-Cities Outpatient Surgery, LLC	Washington	TN	X		
All Other	Twin County Regional Hospital	Grayson	VA			X
All Other	Watauga Medical Center	Watauga	NC		X	X
All Other	Whitesburg ARH Hospital	Letcher	KY		X	X
All Other	Wythe County Community Hospital	Wythe	VA			X
All Other	**Total**			**8**	**17**	**16**

E. Physician Status by Specialty/Employment

Data were developed by specialty to identify physicians employed by Wellmont, employed by Mountain States (or affiliated with Mountain States) and independent physicians. Data on independent physicians were developed using names and specialties for physicians with admitting privileges at Wellmont and/or Mountain States hospitals. The Overlap Flag identifies specialties in which both systems employed physicians.

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

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

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

*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.

Exhibit 8.1A
Health Rankings of Tennessee Counties within the Geographic Service Area

	Tennessee	Carter	Cocke	Greene	Hamblen	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington
Population	6,495,978	57,338	35,479	68,267	63,074	6,679	56,800	17,977	156,595	18,082	125,546
Health Outcomes		48	88	59	54	93	64	44	36	68	19
Length of Life		25	87	57	39	91	60	29	27	63	21
# Premature Deaths	90,439	917	741	1,278	985	163	999	293	2,566	360	1,805
Years of Potential Life Lost Rate (rate per 100,000)	8,696	8,846	12,132	10,276	9,510	13,805	10,433	9,058	8,978	10,604	8,403
Infant Mortality Rate	8.3	10.9	7.2	5.8	6.0		6.5		8.9		9.1
Child Mortality Rate	63.8	89.2	46.0	51.6	57.7		68.0		59.3	81.8	62.5
Quality of Life		81	86	63	76	84	67	68	55	65	28
% Poor or fair health	19	23	27	21	26	29	26	26	22	26	19
Poor physical health days	4.3	5.2	6.4	5.5	6.3	8.2	5.6	5.0	5.4	5.0	4.5
Poor mental health days	3.4	4.8	4.7	4.1	4.7		4.0	3.0	4.5	4.6	3.8
% Low birthweight	9.2	9.8	9.8	9.3	8.6	9.0	8.9	9.9	8.6	8.8	8.4
Health Factors		32	82	41	36	95	28	50	12	19	5
Health Behaviors		41	43	38	31	93	51	30	47	13	9
% Adult smoking	23	31	21	29	23	40	26	28	26	23	24
% Adult obesity	32	29	31	32	30	30	35	31	33	30	31

Exhibit 8.1A
Health Rankings of Tennessee Counties within the Geographic Service Area

	Tennessee	Carter	Cocke	Greene	Hamblen	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington
Food environment index	6.9	6.2	6.2	7.1	6.7	6.8	7.3	7.0	6.7	7.5	7.3
% Physical inactivity	30	32	36	36	33	39	35	34	35	37	30
% Access to exercise opportunities	70	82	74	44	65	4	36	100	77	100	72
% Excessive drinking	9	7		3			5		9		7
% Alcohol-impaired driving deaths	28	27	36	21	34	56	21	9	23	22	31
Sexually transmitted infections (rate per 100,000)	504	169	247	209	293	238	302	88	259	143	201
Teen births (rate per 1000)	47	49	69	48	66	50	51	60	49	45	33
Clinical Care		66	71	38	37	93	31	55	5	77	4
% Uninsured	16	17	18	17	19	17	16	18	15	17	17
PCP Ratio	1388:1	2868:1	1694:1	1496:1	1494:1	6720:1	3537:1	2262:1	754:1	1824:1	596:1
Dentists Ratio	1996:1	3373:1	5068:1	2528:1	1660:1	3340:1	5680:1	3595:1	1424:1	3616:1	1846:1
Mental Health Provider Ratio	786:1	3584:1	3942:1	1004:1	606:1		7100:1	2568:1	865:1	4521:1	345:1
Preventable hospital stays	73	94	114	82	87	181	82	74	86	117	82
% Diabetics	12	15	14	14	14	14	13	15	15	13	11

Exhibit 8.1A
Health Rankings of Tennessee Counties within the Geographic Service Area

	Tennessee	Carter	Cocke	Greene	Hamblen	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington
% Diabetic monitoring	86	84	86	83	87	86	88	82	90	82	89
% Mammogram screening	61.8	58.6	59.7	61.9	63.6	37.3	62.4	63.0	66.5	56.1	63.6
Social & Economic Factors		27	89	55	50	95	22	68	17	16	10
% High school graduation	87	93	94	95	87	78	95	93	92	98	93
% Some college	57.7	49.0	37.1	42.1	46.3	36.8	46.8	35.0	55.2	42.1	66.0
% Unemployment	8.2	8.6	10.8	10.6	8.9	12.3	8.0	9.9	7.5	8.9	7.3
% Children in poverty	27	34	41	30	29	45	31	38	28	29	24
Income Ratio	4.8	4.7	5.1	4.3	4.8	5.0	4.2	4.9	4.9	4.7	5.1
% Children in Single Parent homes	36	29	41	33	31	36	31	24	35	24	31
% Limited Access to Healthy Foods	8	15	10	4	11	1	8	5	14	3	6
Social associations	11.5	14.8	11.2	11.2	14.5	3.0	9.4	16.6	14.7	17.5	13.9
Violent crime (rate per 100,000)	621	206	670	385	526	429	256	476	530	167	415
Injury deaths	78	73	104	99	85	118	96	78	73	83	71
Physical Environment		3	42	9	8	63	19	4	7	1	23

Exhibit 8.1A
Health Rankings of Tennessee Counties within the Geographic Service Area

	Tennessee	Carter	Cocke	Greene	Hamblen	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington
Air pollution - particulate matter	13.8	13.0	13.2	13.1	13.2	13.1	13.1	13.0	13.0	13.1	13.1
% Drinking water violations	4	0	0	7	0	0	3	8	4	0	0
% Severe housing problems	15	13	17	11	13	17	10	13	11	10	15
% Driving alone to work	84	83	84	85	85	87	89	80	87	83	87
% Long commute - driving alone	32	28	39	27	21	43	34	36	24	28	22

Source: University of Wisconsin Population Health Institute. County Health Rankings 2015. *Available at*: www.countyhealthrankings.org

Exhibit 8.1B
Health Rankings of Virginia Counties and Independent Cities within the Geographic Service Area

	Virginia Mean	Bristol City	Buchanan	Dickenson	Grayson	Lee	Norton City	Russell	Scott	Smyth	Tazewell	Washington	Wise	Wythe
Population	8,260,405	17,341	23,597	15,486	15,161	25,185	4,017	28,264	22,640	31,652	44,103	54,907	40,589	29,344
Health Outcomes		111	132	130	74	116	89	122	114	123	133	82	129	85
Length of Life		122	131	127	69	105	97	119	118	106	132	80	124	65
# Premature Deaths	81,691	324	518	331	278	442	61	565	423	616	991	866	765	462
Years of Potential Life Lost Rate (rate per 100,000)	6,192	11,142	12,854	11,985	7,775	9,684	9,229	10,663	10,355	9,688	13,009	8,223	11,198	7,703
Infant Mortality Rate	7.2										6.3	8.8	7.3	
Child Mortality Rate	55.1	109.8	84.7			53.6		64.3	90.4	53.0	83.2	72.5	67.1	49.6
Quality of Life		79	131	130	81	121	72	122	105	132	133	84	127	101
% Poor or fair health	14		29	31	20	29		29	23	29	29	19	24	27
Poor physical health days	3.2		7.6	7.7	3.0	6.0		7.1	4.7	6.9	5.9	3.9	6.0	5.1
Poor mental health days	3.1		5.0	6.4	5.2	5.0		5.0	4.1	5.6	6.3	3.8	6.6	3.6
% Low birthweight	8.3	9.1	10.1	8.5	7.8	8.4	8.6	7.7	9.1	10.1	10.7	8.7	9.1	8.2
Health Factors		107	132	130	109	126	72	125	105	90	96	77	127	82
Health Behaviors		58	103	126	82	70	50	116	121	67	59	81	128	66

Exhibit 8.1B
Health Rankings of Virginia Counties and Independent Cities within the Geographic Service Area

	Virginia Mean	Bristol City	Buchanan	Dickenson	Grayson	Lee	Norton City	Russell	Scott	Smyth	Tazewell	Washington	Wise	Wythe
% Adult smoking	18		30	32	22	25		25	28	22	21	24	33	24
% Adult obesity	28	30	29	29	32	29	29	35	34	31	30	32	32	30
Food environment index	8.3	6.2	7.9	8.3	7.7	8.1	7.2	8.0	7.9	7.8	7.8	8.5	7.5	8.5
% Physical inactivity	22	24	28	32	30	27	24	36	35	23	31	30	38	27
% Access to exercise opportunities	81	97	27	47	45	53	99	43	48	77	52	69	75	71
% Excessive drinking	16					11					10		10	
% Alcohol-impaired driving deaths	31	25	28	70	33	23	0	23	15	28	23	31	28	7
Sexually transmitted infections (rate per 100,000)	427	311	63	300	125	110	344	151	123	183	156	141	340	215
Teen births (rate per 1000)	29	33	48	53	43	57	56	46	49	59	49	45	58	46
Clinical Care		127	133	130	121	131	28	132	111	86	129	93	128	89
% Uninsured	14	16	16	17	20	17	13	17	16	16	17	16	16	17
PCP Ratio	1344:1	2208:1	2982:1	3923:1	3037:1	2830:1	291:1	2032:1	2278:1	1586:1	1165:1	1577:1	2154:1	1625:1

Exhibit 8.1B
Health Rankings of Virginia Counties and Independent Cities within the Geographic Service Area

	Virginia Mean	Bristol City	Buchanan	Dickenson	Grayson	Lee	Norton City	Russell	Scott	Smyth	Tazewell	Washington	Wise	Wythe
Dentists Ratio	1611:1	2890:1	5899:1	15486:1	5054:1	3148:1	1004:1	9421:1	4528:1	1862:1	2940:1	1893:1	4059:1	2668:1
Mental Health Provider Ratio	724:1	1239:1	3933:1	3097:1	15161:1	1199:1	335:1	1229:1	1029:1	989:1	788:1	872:1	1194:1	489:1
Preventable hospital stays	55	110	182	130	75	135	126	160	106	77	130	90	126	70
% Diabetics	10	12	12	11	12	10	10	12	12	11	13	12	13	11
% Diabetic monitoring	87	84	83	85	88	83	91	87	91	88	84	87	86	87
% Mammogram screening	63.4	57.2	51.1	57.9	61.1	54.0	65.5	53.5	60.6	62.0	59.1	63.9	58.8	61.4
Social & Economic Factors		110	130	124	115	122	93	106	87	100	96	60	107	81
% High school graduation	83	73	76	83	83	83	93	81	88	84	74	86	83	82
% Some college	68.2	54.8	41.8	47.5	48.3	51.0	66.1	47.8	52.6	50.0	50.1	59.2	47.9	48.2
% Unemployment	5.5	7.8	9.8	10.0	9.7	9.1	8.7	8.7	7.4	8.4	7.0	6.9	8.8	7.0
% Children in poverty	16	36	33	28	29	39	37	26	27	26	23	21	28	22
Income Ratio	4.8	4.2	5.0	4.6	4.1	4.7	5.3	5.1	4.7	4.4	4.9	4.1	5.3	4.3
% Children in Single Parent homes	30	43	41	33	36	33	45	28	25	36	26	29	31	32

Exhibit 8.1B
Health Rankings of Virginia Counties and Independent Cities within the Geographic Service Area

	Virginia Mean	Bristol City	Buchanan	Dickenson	Grayson	Lee	Norton City	Russell	Scott	Smyth	Tazewell	Washington	Wise	Wythe
% Limited Access to Healthy Foods	4	15	3	0	6	0	7	3	5	4	7	4	5	2
Social associations	11.3	24.9	8.8	4.5	8.6	5.9	17.2	8.8	6.6	11.0	13.1	12.3	10.3	10.6
Violent crime (rate per 100,000)	200	331	145	106	122	131	91	130	109	193	134	104	158	109
Injury deaths	52	80	139	146	84	97	60	94	102	74	106	73	91	86
Physical Environment		124	116	92	55	133	102	109	128	93	78	81	113	75
Air pollution - particulate matter	12.7	13.0	13.0	13.0	13.0	13.1	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0
% Drinking water violations	2		0	0	0	29		0	24	3	0	0	11	4
% Severe housing problems	15	19	12	11	9	16	11	12	11	11	11	11	13	10
% Driving alone to work	77	82	88	84	82	85	89	86	84	87	84	85	84	85
% Long commute - driving alone	38	18	47	46	40	39	18	45	47	26	30	29	29	24

Source: University of Wisconsin Population Health Institute. County Health Rankings 2015. *Available at*: www.countyhealthrankings.org

Exhibit 8.2

Attachment A

Community Health Work Group Charters

Mental Health and Addiction Work Group

Charter

Purpose and Scope:

The Mental Health and Addiction Work Group will evaluate the inventory of mental health and addiction services for adults and children in the area. An important objective is to provide data and analysis that will assist the new proposed regional health system ("Newco") in developing an optimal structure to combat addiction and substance abuse, reduce the number of newborns born into addiction, and to reduce dependency on drugs and alcohol through improved access and support. The findings of the work group will be a source of input into the development of Newco's ten (10) year comprehensive community health improvement plan.

Deliverables:

The work group will produce a document for consideration by Newco that shall consider, but is not limited to, the following:

- Produce an inventory of regional outpatient, community and inpatient services available for adults and children;
- Receive input from physicians, mental health experts, addiction recovery experts and patients with respect to their experiences in the system, and suggestions for improved coordination and gaps in availability of services;
- Assess the national recommendations for best practices in community-based and residential mental health and addiction disorders, and discover opportunities for evolving the regional mental health delivery system toward the national best practices;
- Assess existing gaps in appropriate access points (especially in disadvantaged populations), quality, funding, and use of best practices;
- Identify opportunities to expand education and training for practitioners in mental health and addiction through existing partnerships with East Tennessee State University and potential new partnerships with other organizations;
- Review research-based protective factors and recommend solutions to minimize the initiation of drugs and alcohol in young people and promote mental health and well-being;
- Explore opportunities to better integrate primary care, mental health and addiction services, and to better coordinate care of individuals living with mental disorders and/or addiction across frequently used systems such as judicial, housing, medical and other welfare and family support services; and

- Identify opportunities for enhanced partnerships between Newco and East Tennessee State University, as well as potential new partnerships with other academic institutions, community-based providers and other organizations.

The work group's report will focus on achieving sustainable and measurable improvements in population health in the context of an accountable care community.

Schedule:

The work group will meet periodically at the call of the chair and as scheduled. The schedule shall include meetings which may be open to the public and announced in order to ensure public input in the process. The work group may invite presentations from organizations and individuals with expertise, and may also permit public comment. The work group may identify sub-committees which may meet more frequently to produce material for public review.

Reporting:

The Mental Health Work Group will provide its findings to the Integration Council.

Healthy Children and Families Work Group

Charter

Purpose and Scope:

The Healthy Children and Families Work Group will explore the opportunities and necessary actions for structuring a comprehensive regional approach to child well-being in Northeast Tennessee and Southwest Virginia. The work group will produce a report that identifies the most prominent physical, behavioral and social health problems affecting children in the region and explores their causes, taking into account the social and family supports necessary to equip children to make the strongest possible start in their journey to adulthood. The findings of the work group will be a source of input into the development of the proposed Newco's ten (10) year comprehensive community health improvement plan.

Deliverables:

The work group will produce a document for consideration by Newco that shall consider, but is not limited to, the following:

- Identify the top physical, behavioral and social health and well-being problems experienced by children in the region and explore their root causes;
- Identify gaps in education achievement among children in the region, assessing the impact of these gaps on their ability to thrive as healthy adults. Identify opportunities for how Newco can contribute to improving education achievement, particularly in the area of literacy and basic skills;
- Produce an inventory and gap analysis of past and current efforts that address regional:
    - Pediatric physical and behavioral health services and accessibility;
    - Health and social support services available for children with special needs, such developmental disabilities and physical limitations; and
    - Social service and family and parenting supports available in the region (such as nurse family partnership, Healthy Start, etc.);
- Identify evidence-based best and promising practices in use regionally or elsewhere that may be replicated to improve children's health and well-being;
- Assess the relative ability of the region's public and private sector to improve health outcomes by addressing root causes through evidence-based best and promising practices;
- Identify opportunities to enhance children's health research, training, education, and service provision through existing partnerships with East Tennessee State University and potential new partnerships; and

- Prioritize improvement goals according to their relative importance to children's health and well-being, the commonality of impact across the region, the disparate impact on disadvantaged populations, and the ability of the community to reasonably make an impact on the goals in a sustainable timeframe.

The work group's report will focus on achieving sustainable and measurable improvements in population health in the context of an accountable care community, with prioritization on those areas most likely to be high impact in the region.

Schedule:

The work group will meet periodically at the call of the chair and as scheduled. The schedule shall include meetings which may be open to the public and announced in order to ensure public input in the process. The work group may invite presentations from organizations and individuals with expertise, and may also permit public comment. The work group may identify sub-committees which may meet more frequently to produce material for public review.

Reporting:

The Healthy Children and Families Task Force will provide its findings to the Integration Council.

Population Health and Healthy Communities Work Group

Charter

Purpose & Scope:

The Population Health and Healthy Communities Work Group will explore the opportunity and necessary actions to improve the overall health and well-being of Northeast Tennessee and Southwest Virginia (the "Region") by aligning and mobilizing public and private sector resources – schools, businesses, civic and faith groups, health care providers, government – around a core set of community health improvement goals in the areas of both health care delivery and social determinants of health. Examples of health care delivery goals may include, but not be limited to: increased vaccinations and screenings, improved integration of primary care, dental and mental health services, improved access to services for persons with addictive disorders, and reductions in hospital acquired conditions. Examples of social determinant goals may include, but not be limited to: reduction in teen smoking or pregnancy, improvement of literacy and high school completion, enhanced coordination of services for low-income elderly, or improvements in the variables leading to type 2 diabetes in children.

The findings of the work group will be a source of input into the development of a ten (10) year comprehensive community health improvement plan to be adopted by the new proposed regional health system ("Newco").

Deliverables:

The work group will produce a document for consideration by Newco that shall consider, but is not limited to, the following:

- Identify top health problems in the region and their root causes – both clinical and social – and the health and economic impact of these problems on various public- and private-sector organizations and on disadvantaged populations;
- Identify priorities for coordination of health services for the elderly, including opportunities to coordinate state and federal programs;
- Inventory past and current efforts in the region to address these problems and their root causes;
- Assess the relative ability of the public and private sector to improve health outcomes by addressing root causes – either individually or collectively – through implementation of evidence-based best practices;
- Prioritize improvement goals according to their relative importance to the community's health, the commonality of impact across sectors or the disparate impact on disadvantaged populations, and the ability of the community to reasonably make an impact on the goals in a sustainable timeframe;

- Identify community governance structures used elsewhere in the U.S. that have successfully implemented a health improvement strategy, and contemplate how those examples might inform a culturally appropriate structure for our region;
- Identify opportunities for the East Tennessee State University Academic Health Sciences Center and other academic, business, government and community partners to collaborate with Newco in the creation of an accountable care community.

Schedule:

The Population Health and Healthy Communities Work Group will meet periodically at the call of the chair and as scheduled. The schedule shall include meetings which may be open to the public and announced in order to ensure public input in the process. The work group may invite presentations from organizations and individuals with expertise, and may also permit public comment. The work group may identify sub-committees which may meet more frequently to produce material for public review.

Reporting:

The Population Health and Healthy Communities Work Group will provide its findings to the Integration Council.

Research and Academics Work Group

Charter

Purpose and Scope:

The Research and Academics Work Group will explore the opportunity to improve health and economic growth in Northeast Tennessee and Southwest Virginia (the "Region") by enhancing professional recruitment and research-based funding under a new research and academics partnering strategy between the new proposed regional health system ("Newco") and regional academic institutions, in particular East Tennessee State University. The findings of the work group will be a source of input into the development of Newco's ten (10) year comprehensive community health improvement plan.

Deliverables:

The work group will produce a document for consideration by Newco that shall consider, but is not limited to, the following:

- Identify the fields in which academic institutions, in particular ETSU, can make superior contributions in research and medical education by collaborating with Newco and other community partners;
- Evaluate any institutional changes needed for ETSU and other academic institutions to support the collaborative opportunity with Newco to bolster academics and research;
- Identify institutional changes needed or structures required at Newco to support new and expanded research and undergraduate and graduate medical education opportunities with ETSU and other academic institutions;
- Identify potential long-term strategic research initiatives for Newco, ETSU, other academic institutions, and community collaboratives and estimate ways in which these research initiatives would enhance faculty recruitment and economic growth of the region; and
- Identify opportunities for Newco and its research partners to interface with an effort to create an accountable care community – in particular, what infrastructure is needed in order to use the benefit of research to assist with the priorities identified in the accountable care community model.

Schedule:

The work group will meet periodically at the call of the chair and as scheduled. The schedule shall include meetings which may be open to the public and announced in order to ensure public input in the process. The work group may invite presentations from organizations and individuals with expertise, and may also permit public comment. The work group may identify sub-committees which may meet more frequently to produce material for public review.

Reporting:

The Research and Academics Work Group will provide its findings to the Integration Council.

Exhibit 8.2

Attachment B

Community Health Work Group Membership Lists

Healthy Children & Families

Last Name	First Name	Employer	Title
Staton	Travis	United Way of Southwest Virginia	CEO
Wood	Dr. David	ETSU / Niswonger Children's Hospital	Chair, Department of Pediatrics / CMO
Angelopoulos	Dr. Theodore (Ted)	Emory & Henry School of Health Sciences	Professor
Bailey	Dr. Beth	ETSU, Dept. of Family Medicine	Professor and Director of Research
Baker	Dr. Katie	ETSU, Dept. of Community & Behavioral Health	Assistant Professor
Beilharz	Lisa	Boys and Girls Club of Kingsport	Chief Professional Officer
Carter	Lisa	Niswonger Children's Hospital	CNO, Interim CEO
Casteel	Tommy	Virginia Department of Social Services	Regional Director
Castro	Dr. Sandra	Niswonger Children's Hospital	Pediatric Emergency Physician
Collins	Dr. Melinda	Milligan, School of Sciences & Allied Health	Associate Dean
Counts	Dr. Melody	Virginia Department of Health, Cumberland Plateau District	District Director
Cox	Beth	Johnson City Schools	School Health Coordinator
DeVoe	Dr. Michael	ETSU Pediatrics	Director, Neonatology Professor and Vice Chair
Everhart	Aubrey	Appalachian Mountain Project Access	Executive Director
Feierabend	Margaret	Bristol Promise; Bristol City Council Member	Chairman (Bristol Promise)
Ferguson	Hugh	The First Bank & Trust Company	SVP/Energy Banker
Gendron	Dr. Richard	Holston Medical Group	Vice President, Pediatrician
Gouge	Dr. Natasha	MSMG Pediatrics	PhD Licensed Clinical Psychologist
Hale	Dr. Kim	ETSU, College of Education	Associate Dean/ Early Childhood Education
Holloway	Paula	Watauga Behavioral Health	Children & Youth Svcs Coord
Jaishankar	Dr. Gayatri	ETSU Pediatrics	Pediatrician
Kozinetz	Dr. Claudia	ETSU, Public Health	Professor and Chair, Department of Biostatistics and Epidemiology
Mabrey	Gary	Washington County/ Johnson City/ Jonesborough Chamber of Commerce	President & CEO
Midgett	Linda	People Incorporated of Virginia	Director, Community Services
Mobley	Julie	Integrated Solutions Health Network	Population Health Care Manager

Montgomery	Paul	Northeast State	VP, Access & Development
Myers	Dr. Pam	Highlands Pediatrics	Pediatrician
Perkins	James	Wellmont/Healthways	System Director Wellmont Diabetes Treatment Centers
Perry	Tim	Frontier Health	Director, Children's Outpatient Services
Pillion	Dr. Todd	Bristol Pediatric Dentistry	Pediatric Dentist
Polaha	Dr. Jodi	ETSU	Associate Professor Family Medicine
Powers	Catherine	ETSU	Professor of Nursing
Ratliff	Dr. Brian C.	Washington County Virginia Schools	Superintendent of Schools
Rhinehart	Beth	Bristol Chamber of Commerce	President /CEO
Robinson	Haydee	Dickenson County Schools	Superintendent
Robinson	Dr. Mike	Smyth County Virginia Schools	Superintendent of Schools
Skinner	Glen "Skip"	LENOWISCO Planning District Commission	Executive Director
Smith	Dr. Michael	ETSU, Dept. of Social Work	Department Chair
Stephens	Stephanie	Appalachian Association for the Education of Young Children	President
Stroud	Ellen		
Teague	Donna	Johnson County Community Hospital	LPN
Terry	Kathlyn	Appalachian Sustainable Development	Executive Director
Tipton	Lisa	Families Free	Executive Director
Thomas	Cynthia	TN Department of Health	Assistant Medical Director
Tweed Hill	Judy	Alpha Natural Resources	VP of Benefits
Wells	Conni	Mountain States Health Alliance	Patient/Family Driven Care Mgr
Werth	James	Stone Mountain Health Services, FQHC	Behavioral Health and Wellness Services Director
Wiley	Mary	Wellmont Hancock County Hospital	RN

MENTAL HEALTH & ADDICTION

Last Name	First Name	Employer	Title
Greene	Eric	Frontier Health	Senior VP
Kidd	Dr. Teresa	Frontier Health	President and CEO
Abner	Dr. John Paul	Milligan College	Professor of OT & Psychology
Adler	Mike	Counseling and Consultation Services	Clinical Executive Director
Bailey	Marlene	Woodridge Hospital	Director, Behavioral Health Programs
Bangle	Rev. Jim	Retired Lutheran pastor, LCSW, Law Enforcement Chaplain	
Benedetto	Kathy	Frontier Health	SVP, Children & Youth Services
Bowen	Diane	Frontier Health	Director of Compliance and Performance Improvement
Chase	Anna	Mount Rogers CSB	Director of Youth and Family Services
Collins	Margie	City of Bristol, VA Circuit Court	Drug Court Coordinator
Fox	Jeff	Highlands Community Services	Executive Director
Gonder	Karen	Mountain States Health Alliance	Human Resources, retirement plans
Goodkin	Dr. Karl	ETSU, Dept. of Psychiatry	Chair
Griffith	Dr. Jay	ETSU, Dept. of Psychiatry & Behavioral Health	Training Program Director
Hagy	John	Russell County Medical Center	Director of Clearview Psychiatric Center
Holmes	Rebecca	Highlands Community Services	Clinical Director
Jessee	Dr. Randy	Frontier Health	Senior VP, Specialty Services
Jones	Kristie	Cumberland Mountain CSB	Director of MH Services
Keen	Doug	Wellmont Health System	Program Manager Department of Psychiatry
Ketron	Chris	NE State Community College	Adjunct Faculty
Larsen	Mark	Mount Rogers CSB	Director of Adult Behavioral Health Services
Lindenbusch	Sue	Wellmont Health System	SVP, oncology & behavioral health
Loyd	Dr. Stephen	VA Mountain Home	Associate Chief of Staff
McClaskey	Cynthia	SW VA Mental Health Institute	Director
Melton	Dr. Sarah	Gatton College of Pharmacy at ETSU	Associate Professor of Pharmacy Practice
Melton	Dr. Hughes	Mountain States Health Alliance	Director of GME Program

Mental Health & Addiction
Steering Committee List

Mills	Dr. Lori	Milligan College	Professor of Psychology
Moore	Elliott	Mountain States Health Alliance	VP, Government Relations
Moser	Dr. Michele	ETSU	Psychologist
Mullins-Potter	Karrie	Frontier Health	Peer Specialist, VA Operations
O'Dell	Sandy	Planning District One	Executive Director
Pack	Dr. Rob	ETSU	Assoc. Dean Academic Affairs
Page	Joe	Frontier Health	Senior VP, TN Adult Services
Plummer	Dr. Robert (Bob)	ETSU	AVP, University Advancement
Rainey	Alice	Retired	Member, SAGE: research group for examining needs and service gaps for seniors
Rice	Dr. Judy	ETSU College of Nursing	Interim Director, Graduate Programs
Richards	Scott	Emory & Henry College, School of Health Sciences; Mel Leamon Free Clinic of SWVA	Department Chair Family Practice / Psychiatric PA
Robshaw	Shannon	Technical Assistance Network for Children's Behavioral Health, University of Maryland	Consultant
Ross	Hon. Todd	Hawkins County, TN	Judge
Taylor	Ken	Frontier Health	Division Director, VA Child & Family Services
Testerman	Brenda	Frontier Health	VA Operations, MH Recovery Coach
Werth	James	Stone Mountain Health Services	Behavioral Health & Wellness Services Director
White	Lindy	Franklin Woods Community Hospital / Woodridge Hospital	CEO
Williams	Dr. Douglas	Mountain Empire Neurology Associates	Neurologist

Population Health & Healthy Communities

Last Name	First Name	Employer	Title
Hamilton	Lori	K-VA-T Food City	Health Educator
Wykoff	Dr. Randy	ETSU College of Public Health	Dean
Belcher	Phil	Eastman Chemical Company	Health and Welfare Manager
Bishop	Marilyn	Mountain States Medical Group	Medical Director Occupational Medicine
Blackwelder	Dr. Reid	American Academy of Family Physicians	
Blevins	Shannon	UVA Wise	Dir., Economic Development
Brillhart	Catherine	City of Bristol	Councilwoman
Brock	Jenny	City of Johnson City	Commissioner
Buck	Linda	Rural Health Consortium	Director
Cantrell	Sue	SWVA Health Authority	LENOWISCO Health Director and Vice Chairman
Cook	Heather	Healthy Kingsport	Director
Counts	Melody	Cumberland Plateau Health District	District Health Director
Domst	Ronald	Johnston Memorial Hospital	Retired, Volunteer
Eastridge	Dr. Wesley	Mountain Region Family Medicine	Physician
English	Rebekah	NE TN Regional Health Department	Regional Director
Everhart	Aubrey	Appalachian Mountain Project Access	Executive Director
Farmer	Barbara	Pleasant View UMC; Wesley Clinic	Associate Pastor; Volunteer
Franko	Dr. John	ETSU	Family Medicine
Gail	Dick	AEP	Retired plant manager
Glass	Charlie	Greater Kingsport Family YMCA	Executive Director/CEO
Hammonds	Kristie	Frontier Health	SVP, Operations
Harris	Matthew	Mountain States Rehabilitation – JMH	Physical Therapist, Athletic Trainer
Holden	Dr. Lynn	King University	Dean, School of Nursing
Johnson	Stan	Great Body Company	Owner
Kent	Martin	United Company	President
Mayes	Gary	Sullivan County Health Department	Regional Director
Michael	Dr. Gary	Clinch River Health Services, Inc	Family Practice Physician

Population Health & Healthy Communities
Steering Committee List

Morgan	Ed	City of Abingdon	Mayor
Moulton	Dr. David	State of Franklin Healthcare Assoc.	
Nehring	Dr. Wendy	ETSU	College of Nursing
Perkins	James	Wellmont Health System	HVMC/BRMC Diabetes Treatment Center
Purdue	Malcolm	Stone Mt Health Services (FQHC)	Executive Director
Seligman	Dr. Morris	MSHA	EVP, CMO
Sensibaugh	David	Integrated Solutions Health Network	VP, integrated health management
Snodgrass	Dr. Jeff	Milligan College	Chair, Department of Occupational Therapy
Wiley	Mary	Wellmont Hancock County Hospital	RN

Research & Academics

Last Name	First Name	Employer	Title
Bishop	Dr. Wilsie	East Tennessee State University	VP for Health Affairs and COO
Schrum	Jake	Emory & Henry	President
Angelopoulos	Dr. Theodore (Ted)	Emory & Henry School of Health Sciences	Professor
Calvert	Linda	Northeast State	Director, WIA Grant & Bridge
Campbell	John	AccelNow	Executive Director
Campbell	Dr. Steve	Northeast State	VP for Business Affairs
Carmack	Duffy	Southwest VA Higher Ed Center	CFO/ Interim Director
Clark	Dr. Andy	ETSU	Professor of Clinical Nutrition Associate Dean of Research and Clinical Practice
Collins	Dr. Cathie	UVA Wise	Chair, Dept. of Nursing
Dawson	Dr. B. James	Lincoln Memorial University	President
Davis	Dr. Mary Lee	Michigan State University	Sr. Advisor, Dept. of Family & Community Medicine - emeritus
Dishner	Dr. Nancy	Niswonger Foundation	President & CEO
Drinnon	Dr. Joy	Milligan College	Director of Undergraduate Research/Professor of Psychology
Duncan	Dr. Bill	ETSU	Vice Provost for Research, Office of Sponsored Programs
Ehret	Charlene	James H. Quillen Veterans Administration Medical Center	Director
Fincher	Dr. Lou	Emory & Henry	Dean, School of Health Sciences
Fowler	Dr. Scott	Holston Medical Group	President
Fowlkes	Rachel	Southwest VA Higher Ed Center	Retiring Director
Gilliam	Dr. Janice	Northeast State Community College	President
Grandy	Joe (William)	Ferguson	General Manager
Greer	Dr. Bill	Milligan College	President & CEO
Henderson	Rebecca	Strategic Priorities Consulting	Consultant

Research & Academics
Steering Committee List

Henry	Donna	UVA Wise	Chancellor
Kendall	Martha	Johnston Memorial Hospital	Speech / Language Pathologist
Khoury	Dr. Amal	ETSU – Public Health	Chair, Dept of Health Svcs Mgt & Policy
Linville	Dr. David	ETSU	Associate Dean for GME
Lugo	Dr. Ralph	Gatton College of Pharmacy ETSU	Professor and Chair of Pharmacy Practice
Lura	Dr. Richard (Dick)	Milligan College	Professor of Chemistry
Mayhew	Dr. Susan	Appalachian School of Pharmacy	Dean
Means	Dr. Robert (Bob)	ETSU, Quillen College of Medicine	Dean
Melton	Dr. Hughes	Mountain States Health Alliance	Director of GME Program
Mitchell	Dr. Kathy	Virginia Highlands Community College	Dean, Nursing & Allied Health
Moody	Dr. Nancy	Tusculum College	President
Moorman	Dr. Jon	ETSU	Vice Chair, Research & Scholarship/Residency Program Director
Nida	Dr. Maurice	Wellmont Health System	Director, Osteopathic Medical Education / LMU adjunct professor of medicine
Niday	Pat	Mountain States Health Alliance	Chief Learning Officer
Ong	Dr. Han Chuan	King University	Dean, College of Arts & Sciences
Phillips	Dr. Kenneth	ETSU	Interim Assoc. Dean, Research
Pope	Pat	QSource (Quality Improvement Network for State of TN)	Practice Solution Advisor
Prill	Dr. Sue	Wellmont Cancer Center	Medical Director, Breast Center
Ray	Dr. Richard	King University	Interim President
Rinehart	Dr. Andrew	Glytec	Chief Medical Officer
Runnels	Dr. Clay	Mountain States Health Alliance	CMO, Washington County TN
Seligman	Dr. Morris	Mountain States Health Alliance	EVP, CMO
Shipley	Lindsey	ETSU Quillen College of Medicine	Student (Joint MD/MPH program)
Stepanov	Dr. Nonna	Mountain States Health Alliance	Director of Research
Tillman	Dr. Ken	ETSU - College of Nursing	Associate Dean of Academic Programs
Tooke-Rawlins	Dr. Dixie	Via College of Osteopathic Medicine	
Walker	Clay	NETWORKS Sullivan Partnership	CEO

Exhibit 8.3

Schedule of Public Meetings Conducted by the Community Health Work Groups

Community Input Work Groups
Steering Committee Meetings and Roundtable Meetings

Mental Health & Addiction Steering Committee *(Meetings held from 9:30am-Noon)*

- Thursday, August 20th, Millennium Centre, Johnson City
- Thursday, September 17th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, October 21st, Millennium Centre, Johnson City
- Thursday, November 19th, Southwest Virginia Higher Education Center, Abingdon
- Friday, December 18th, Millennium Centre, Johnson City

Healthy Children & Families Steering Committee *(Meetings held from 9:30am-Noon)*

- Tuesday, September 8th, Southwest Virginia Higher Education Center, Abingdon
- Tuesday, October 13th, Millennium Centre, Johnson City
- Tuesday, November 10th, Southwest Virginia Higher Education Center, Abingdon
- Tuesday, December 8th, Millennium Centre, Johnson City
- Tuesday, January 5th, Southwest Virginia United Way office (subcommittee meeting)
- Tuesday, January 12th, Southwest Virginia Higher Education Center, Abingdon

Population Health & Healthy Communities Steering Committee *(Meetings held from 9:30am-Noon)*

- Monday, August 24th, Southwest Virginia Higher Education Center, Abingdon
- Monday, September 28th, Millennium Centre, Johnson City
- Monday, October 26th, Southwest Virginia Higher Education Center, Abingdon
- Monday, November 16th, Millennium Centre, Johnson City
- Monday, January 18th, Southwest Virginia Higher Education Center, Abingdon

Research & Academics Steering Committee *(Meetings held from 9:30am-Noon)*

- Thursday, September 24th, Millennium Centre, Johnson City
- Thursday, 8th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, December 2nd, Millennium Centre, Johnson City
- Wednesday, January 13th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, January 27th, ETSU, (subcommittee meeting)

All Work Groups Meetings

- Monday, November 16, Millennium Centre, Johnson City, Topic: Accountable Care Communities *(9:00-10:30am)*
- Friday, December 18, Millennium Centre, Johnson City, Topic: Impact of Opioids on Appalachia *(9:30-11:30am)*
- Tuesday, February 2, Millennium Centre, Johnson City, Topic: Early Brain Development and Toxic Stress *(9:00-10:30am)*

Roundtable Meetings *(Meetings for Community Members; meetings held from 5:30-7:30pm)*

- Thursday, August 13th, Tennessee College of Applied Technology, 425 TN-91, Elizabethton, Tenn.
- Thursday, August 20th, Southwest Virginia Higher Education Center, One Partnership Circle, Abingdon, Va.
- Tuesday, September 15th, Holston Hills Community Golf Course (Multi-Purpose Room), Marion, VA
- Thursday, September 24th, Tennessee National Guard Armory, 615 South Main Street, Erwin, TN (Unicoi)
- Tuesday, September 29th, Russell County Conference Center, Lebanon, VA
- Thursday, October 1st, Food City Press Room, Kingsport, TN
- Tuesday, October 6th, Crooked Road Tech Center, Duffield, VA
- Thursday, October 15th, Bristol Motor Speedway, Bristol, TN
- Tuesday, October 20th, The Inn at Wise (Ballroom), Wise, VA
- Wednesday, October 21, United Way 2020 Summit with Robert Wood Johnson Foundation, Southwest Virginia Higher Education Center
- Thursday, October 22nd, Memorial Park Community Center, 510 Bert Street, Johnson City, TN

Exhibit 8.4

Attachment A

Mountain States' Charity Care Policy

Policy Manual:	Adminstration/Operational
Manual Section:	Fiscal Services - Policies
Policy Number:	CBO-400-011
Effective Date:	October 4, 2013
Supersedes:	February 2013
Reviewed Date:	September 12, 2013

I. TITLE: CHARITY POLICY – FISCAL SERVICES

II. PURPOSE:

To outline the guidelines that ensure MSHA reviews all requests for charity in a fair and equitable manner.

III. PATIENT-CENTERED CARE PRINCIPLES:

All team members are considered as caregivers.

IV. SCOPE:

Mountain States Corporate Billing Office (CBO) team members

V. FACILITIES/ENTITIES:

MSHA Corporate

Tennessee: FWCH, IPMC, JCCH, JCMC, QRH, SSH, WPH, Niswonger Children's Hospital, Kingsport Day Surgery, IPMC Transitional Care, Princeton Transitional Care

Virginia: DCH, JMH, NCH, RCMC, SCCH, Clearview Psychiatric Unit, Francis Marion Manor Health & Rehabilitation

VI. DEFINITIONS:

Not Applicable

VII. POLICY:

A. Mountain States Health Alliance has established a strong mission to meet the medical needs of the communities it serves. It is the mission of Mountain States Health Alliance to:

1. Treat all patients equally- with dignity and respect
2. Evaluate all requests for financial assistance using established general guidelines while allowing for unique financial circumstances
3. Respond promptly to patient inquiries regarding their bills and requests for financial assistance
4. Ensure outside collection agencies follow hospital billing and collection guidelines
5. Follow a consistent collection protocol that ensures MSHA communicates with the patient regarding their financial liability prior to services being rendered

B. Mountain States Health Alliance recognizes its obligation to provide quality health care to those who are unable to pay. Given the alliance's limited financial resources, this policy is designed to balance the hospital's obligation with its financial resources and to ensure that those receiving free or partially compensated care meet defined financial qualifications. All charity cases must be accompanied by a completed financial assistance form and supporting documentation.

1. Charity eligibility will be determined by review of the Financial Assessment Form, documents presented in support of the information on the Financial Assessment Form, and verification of assets.
2. Charity eligibility determination will be made post-service and on an episodic basis with the exceptions outlined below:
    a. Lactation consultations
        i. If approved, the charity determination will be in effect for the duration of the breastfeeding of that child, which could encompass multiple encounters.
    b. Oncology services
        i. If approved, the charity determination will be in effect for six (6) months or duration of treatment regimens, whichever occurs first.
    c. Appropriately referred Appalachian Mountain Project Access patient visits are extended 100% charity per contractual arrangement.
    d. As of July 1, 2011, patient days covered by Tennessee Department of Mental Health grant are extended 100% charity per grant provisions.
    e. High dollar implant cases may be pre-screened for charity prior to procedure.
3. Charity eligibility encompasses the following patients: Patients with Medicaid eligibility after the date of service, patients that are deceased with no estate, patients with Virginia SLH funds exhausted and Medicaid eligible encounters where benefits limits have been exhausted.
4. Mountain States Health Alliance charity guidelines are based on the National Poverty Guidelines for the applicable year.
5. Charity awards are not based solely on income.
    a. Unique financial circumstances are weighed and assets will be verified and these factors can change the category of eligibility.
6. The decision as to the amount of charity write-off will be made by Customer Service Center supervision under the direction of the Customer Service Center Director.
7. Elective or non life threatening procedures are not eligible for charity consideration.
8. Charity determination may be retroactive for all dates of services, as determined by the screener at the time of the application.

9. Charity determinations are based on the current, outstanding balance of an account.
    a. Any payments previously made to the account balance are not refunded.

LINKS:

National Poverty Guidelines

_____ _____

Chair, MSHA Board Date

_____ _____

President and Chief Executive Officer, MSHA Date

Exhibit 8.4

Attachment B

Mountain States' Credit and Collection Policy - Patient Accounts

Policy Manual:	Administration/Operational
Manual Section:	Fiscal Services - Policies
Policy Number:	ADM-400-018
Effective Date:	January 9, 2015
Supersedes:	February 2014
Reviewed Date:	January 8, 2015

I. TITLE: CREDIT AND COLLECTION POLICY – PATIENT ACCOUNTS

II. PURPOSE:

To outline general guidelines that allows for a fair and equitable system for credit and collection of payments from patients served by Mountain States Health Alliance.

III. SCOPE:

All team members

IV. FACILITIES/ENTITIES:

MSHA Corporate

Tennessee: FWCH, IPMC, JCCH, JCMC, QRH, SSH, UCMH, WPH, Niswonger Children's Hospital, Princeton Transitional Care, Unicoi County Nursing Home

Virginia: DCH, JMH, NCH, RCMC, SCCH

V. DEFINITIONS:

A. **Self-pay portion:** The amount owed by patients without insurance or deductible and co-payments required of patients with insurance coverage.

B. **Non-emergent:** If the procedure being ordered is on the established non-emergent classification table or the diagnosis code supporting the order is on the non-emergent code list, the encounter would be deemed non-emergent.

VI. POLICY:

A. Mountain States Health Alliance has established a strong mission to meet the medical needs of the communities it serves. It is the mission of Mountain States Health Alliance to:

1. Treat all patients equally – with dignity and respect.
2. Evaluate all requests for financial assistance using established general guidelines while allowing for unique financial circumstances.
3. Respond promptly to patient inquiries regarding their bills and requests for financial assistance.
4. Ensure outside collection agencies follow facility/entity billing and collection guidelines.
5. Follow a strong collection program that enables Mountain States Health Alliance is able to communicate financial responsibility to the patient prior to

service.

B. Mountain States Health Alliance (MSHA) has established sound guidelines to provide direction to team members in their interactions with patients and guarantors.

1. Patients receiving services at MSHA facilities will be treated under the payment arrangement and financial options outlined in this policy.
2. MSHA recognizes its obligation to provide quality health care to those who are unable to pay.
3. In addition, MSHA provides financial counselors to help uninsured patients determine sources of payment for medical bills and to help patients determine eligibility for programs such as TennCare or Medicaid.
4. Patients with no health insurance will receive a discount on their facility/entity bills at MSHA.

VII. PROCEDURE:

A. **Payment arrangements**

1. All patients will be required to submit coverage information prior to a service being rendered.
2. Mountain States Health Alliance will bill insurance carriers (including managed care plans) as dictated by contracts, after verification of benefits.

B. **Pre-Admissions**

1. Mountain States Health Alliance will pre-admit all patients when possible.
2. The method of payment will be verified prior to the patient's admission.

C. **Non-Emergent Services**

1. Patients scheduled for these services will be evaluated and informed of financial liability PRIOR to admission.
2. The patient will be required to either pay 50% of their estimated out-of-pocket liability or agree to monthly payment arrangements on the full estimated amount, with the first payment due before the service is rendered.
3. If satisfactory payment arrangements cannot be reached with the patient prior to the scheduled procedure time, the procedure will be postponed until acceptable payment arrangements can be established.

D. **Emergent Services**

1. Mountain States Health Alliance will perform these services for any patient regardless of their ability to pay.

E. **Patient Financial Options**

1. Mountain States Health Alliance provides the following guidelines for payment options.

2. Financial counselors are available to assist patients and their families with financial help, as needed.
3. The following payment options are available at Mountain States Health Alliance facilities:
    a. **Cash Payments**
        i. If payment at discharge is not possible, the patient and/or patient's family will be reminded that the balance is due within thirty (30) days of discharge or date of service.
    b. **Credit Card Payments**
        i. Mountain States Health Alliance will accept credit card payments for patient balances.
        ii. Accepted cards are Visa, MasterCard, American Express and Discover.
    c. **Pre-Service Pay Discounts**
        i. A "pre-service pay" discount of up to 10% may be offered to patients if their liability is $5000 or less.
        ii. If the liability is greater than $5000, a maximum discount of $500 can be offered, using the steps outlined in the Financial Counselor Guidelines policy.
    d. **Catastrophic High Dollar Inpatient Accounts**
        i. In special circumstances, a discount in excess of the established discounting rates can be granted.
            1) When determining this discount, many factors will be taken into consideration including the cost of care rendered and the Medicare inpatient Diagnosis Related Group (DRG) rate.
        ii. This offer requires the approval of the Vice President (VP) of Revenue Cycle.
    e. **Insurance Company Requesting Audit**
        i. A 5% discount can be offered to a non-contracted payer.
        ii. The Managed Care department must be notified of any requests and included in negotiations.
        iii. The account must be thoroughly documented to reflect all negotiations.
    f. **Payment Arrangements**
        i. Payment arrangements are available within the following guidelines:
            1) If the balance is less than $500, the patient can make payments up to twenty (20) months, with a minimum monthly payment amount of $25.00.

a) Account must not be with a collection agency.

2) If the balance is greater than $500, the patient can make payments up to thirty-six (36) months but must make a minimum payment of $50.00 per month.

a) Account must not be with a collection agency.

g. Self Pay ED Visits

i. When possible, MSHA will provide an estimate of care rendered to self-pay patients before they leave the Emergency Department (ED).

ii. These estimated charges will be calculated at a higher discounted rate than our standard uninsured rate.

iii. The patient will have the option to pay this discounted amount in full at that time, pay the discounted amount in full within three (3) business days after the ED visit, or decline the offer.

iv. If declined, the patient will be responsible for all charges relating to the ED visit, after the standard uninsured discount is applied.

h. **Exceptions to above**

i. In extenuating circumstances, the above may be deviated from by Revenue Cycle Senior Management.

i. **Charity**

i. Mountain States Health Alliance recognizes its obligation to provide quality health care to those who are unable to pay.

ii. Refer to Charity Policy – Fiscal Services for detailed information on the MSHA charity guidelines.

j. **Collection Agencies**

i. When it is determined that a patient has not responded to our requests for balance resolution, an account can be referred to an outside collection agency for collection assistance.

LINKS:

Charity Policy - Fiscal Services CBO-400-011

Financial Counselor - Contracted Medicaid Eligibility Guidelines CBO-400-010

_____ _____

President and Chief Executive Officer, MSHA Date

Exhibit 8.4

Attachment C

Mountain States' Collection Agency Process - Fiscal Services

Policy Manual:	Administration/Operational
Manual Section:	Fiscal Services
Policy Number:	CBO-400-007
Effective Date:	April 11, 2014
Supersedes:	April 2013
Reviewed Date:	April 11, 2014

I. TITLE: COLLECTION AGENCY PROCESS – FISCAL SERVICES

II. PURPOSE:

To detail process of accounts placed with outside collection agencies.

III. PATIENT-CENTERED CARE PRINCIPLES:

All team members are considered as caregivers.

IV. SCOPE:

All MSHA Corporate Business Office (CBO) Team Members

V. FACILITIES/ENTITIES:

MSHA Corporate

Tennessee: FWCH, IPMC, JCCH, JCMC, QRH, SSH, UCMH, WPH, Niswonger Children's Hospital, Kingsport Day Surgery, IPMC Transitional Care, Princeton Transitional Care, Unicoi County Nursing Home

Virginia: DCH, JMH, NCH, RCMC, SCCH, Clearview Psychiatric Unit, Francis Marion Manor Health & Rehabilitation, Norton Community Physicians Services (NCPS), Community Home Care (CHC)

BRMMC owned and managed practices

Home Health/Hospice

ISHN

VI. DEFINITIONS:

Not Applicable

VII. POLICY:

Accounts the CBO's self pay collection unit is unable to successfully collect are placed with an outside collection agency on a regular basis.

VIII. PROCEDURE:

A. Monthly, accounts are transferred to the bad debt file on the Patient Accounts system and an electronic file of these accounts are sent to outside collection agencies for further collection efforts.

B. MSHA utilizes one (1) primary collection agency; one (1) secondary agency.

C. Monthly, the agencies send electronic files to MSHA containing payments received in their office and posted in their system that day to MSHA accounts.

1. These payments are applied to the patient's accounts on the Patient Accounts system.

D. Daily, electronic payment files are sent back to the agencies from MSHA containing payments made at MSHA and posted to the patient's accounts.

1. The agencies update this payment information back into their collection system.

E. Monthly, the agencies send checks and remittances to the CBO detailing the total payments applied to the accounts in the month regardless of where the payments were made.

1. These remittances list the paid amount, patient name, date of payment, amount due the agency and the amount due MSHA.
2. The amount paid, amount due the agency and the amount due MSHA are totaled at the end of the remittance.
3. The amount due the agency is the negotiated fee for services as outlined in the contracts.
4. The remittances are balanced to the Patient Accounts system reports for accuracy.
5. Check requests are submitted to Accounts Payable for the amounts verified due to the agencies and the payments are mailed by the Accounts Payable department.

F. All accounts; regardless of primary payer classification, remain with the primary agencies as long as an acceptable payment arrangement has been established.

1. Accounts deemed uncollectible by the agencies are closed and returned to MSHA.
    a. Examples of uncollectible accounts are bankruptcies and deceased patients with no estate.
2. These accounts are sent back via electronic file transfer and a credit adjustment to the account in Patient Accounts is posted to zero out the balance.

G. Accounts that the primary agency has been unsuccessful in collecting are sent to a secondary agency for collection efforts.

1. Reporting of payments and monthly billing of services occurs in the same manner at the primary agency process.

_____ _____

Vice President, Revenue Cycle, MSHA Date

Exhibit 8.4

Attachment D

Mountain States' Code of Ethics and Business Conduct

Policy Manual:	Administration/Operational
Manual Section:	Board
Policy Number:	BD-000-006
Effective Date:	August 2, 2013
Supersedes:	June 2011
Reviewed Date:	July 8, 2013

I. TITLE: CODE OF ETHICS AND BUSINESS CONDUCT

II. PURPOSE:

To describe the ethical framework within which Mountain States Health Alliance conducts its patient care and business operations.

III. PATIENT-CENTERED CARE PRINCIPLES:

All team members are considered as caregivers.

IV. SCOPE:

All team members

V. FACILITIES/ENTITIES:

Tennessee: FWCH, IPMC, JCCH, JCMC, QRH, SSH, WPH, Niswonger Children's Hospital, Kingsport Day Surgery, IPMC Transitional Care, Princeton Transitional Care

Virginia: DCH, JMH, NCH, RCMC, SCCH, Clearview Psychiatric Unit, Francis Marion Manor Health & Rehabilitation, Norton Community Physicians Services (NCPS), Community Home Care (CHC)

BRMMC, MSMG owned and managed practices

Home Health/Hospice

ISHN

VI. DEFINITIONS:

Not Applicable

VII. POLICY:

A. Mountain States Health Alliance, its Board of Directors, Medical/Dental Staff, employees, and independent contractors conduct patient care according to the Patient-Centered Care Philosophy and all business operations in an ethical manner. Our behavior is guided by our mission, vision, and core values statements and the following general principles.

1. We shall treat everyone with dignity, respect, and courtesy.
2. All team members are considered as caregivers, and all caregivers cooperate with one another through a common focus on the best interests and personal goals of the patient.

3. Our primary commitment is to the health, safety, and rights of the patient, whether an individual, family, friends, group, or community.
4. Care is provided in a healing environment of comfort, peace, support, openness and honesty.
5. We shall provide services only to those patients for whom we can safely care within this organization, and no patient with a medical necessity will be turned away due to an inability to pay or for any other reason unrelated to patient care.
6. Care is customized and reflects patient needs, values, and choices and is based on continuous healing relationships, with the patient being the source of control for their care.
7. Patient confidentiality is preserved with knowledge and information being shared only among care partners, physicians, and other caregivers with a "need to know".
8. Caregivers owe the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
9. We shall adhere to a uniform standard of care throughout the organization.
10. We shall continuously seek to improve our skills and the quality of our care and add new technology in a prudent manner, while striving to cut costs.
11. We shall make clinical decisions on identified patient health care needs, not financial risks or incentives.
12. We shall abide by all professional standards, laws and regulations governing the operations of our organization, and we shall fairly and accurately represent ourselves and our capabilities.
13. We shall meet, or exceed, all standards and requirements imposed upon us by licensing and accrediting bodies.

VIII. PROCEDURE:

A. The Code of Ethics and Business Conduct conveys the standards of ethical and legal behavior that is expected of all team members, Physicians/Allied Health Personnel, Independent contractors, and vendors.

B. The Code of Ethics and Business Conduct booklet is provided to all new team members during orientation, to new vendors or independent contractors and is provided to all new Physicians/Allied Health Personnel.

   1. Individuals receiving a hard-copy of The Code of Ethics and Business Conduct must sign an acknowledgment of receipt or complete a computerized acknowledgment of receipt.
   2. The Code of Ethics and Business Conduct document is accessible at all times in electronic format on the MSHA Intranet.

C. The Code of Ethics and Business Conduct is reviewed annually and modifications

are submitted to the Board for approval.

D. All individuals subject to the Code of Ethics and Business Conduct are expected to adhere to the Standards.

1. Failure to do so will result in disciplinary action up to and including termination of employment, removal from the Medical Staff or be excluded as a participating vendor.

LINKS:

Code of Ethics and Business Conduct – MSHA

Code of Ethics and Business Conduct – Norton Community Hospital

_____ _____

Chair, MSHA Board Date

_____ _____

President and Chief Executive Officer, MSHA Date

Exhibit 8.5

Attachment A

Wellmont's Patient Bill of Rights

Wellmont Health System

Effective:	*03/2011*
Approved:	*10/2015*
Last Revised:	*10/2015*
Custodian:	*Sharon Webb: ADMINISTRATIVE SECRETARY*
Policy Area:	*Single Billing Office*
Regulatory:	
Applicability:	*Wellmont Health System*

Charity Care

Policy Statement:

Wellmont Health System, a not-for-profit provider, recognizes its role in the community to provide medically necessary, quality care services to all people regardless of their ability to pay.

Wellmont Health System acknowledges its responsibility as a tax-exempt organization to provide medically necessary health care services for the community's uninsured or underinsured population. However, Wellmont Health System is also tasked with managing its resources in a fiscally sound manner and, therefore, sets forth the following charity care policy which is designed to help those who cannot afford to pay for those medically necessary health care services. This charity care policy is only applicable for services that are deemed to be medically necessary and non-elective. Charity care status will be granted to patients for 6 months. A new application will be required should the patient need coverage beyond 6 months.

COPY

Procedure:

Wellmont Health System proactively pursues patients who may be candidates for charity care through the following processes:

- Patients who walk-in or telephone the Business Office or a clinical office setting stating they are having problems paying their bills.
- Patients who are identified through telephone or statement collection procedures.
- Referrals from registration points that have identified possible indigent or charity situations.
- Inquiries from local charitable or religious organizations who call on behalf of patients seeking financial assistance.
- In-house social services whom, while working with patient or patient's family, has identified a financial need.
- All self-pay patients are referred to a Program Eligibility Specialist or to an outsourced agency that helps to qualify eligible patients for Medicaid and any known charitable programs.

Approval Process:

A charity care application is given or mailed to the patient/guarantor. The application shall include the following information:

A. Proof of address

B. Proof of total household income (copy of pay stubs, W-2's,) including copies of most recently filed tax return

C. Complete current bank statements, checking, savings and investments

D. Completed financial screening application

When a complete application is received, an applicant's income is verified and compared against federal poverty guidelines based on household size. (**Household** is defined as an individual, spouse, minor children under the age of 18 years which may include biological, step and adoptive children. Other persons living in the home, including friends and/or other relatives, etc. will not be counted as household members unless the person is included as a dependent on the income tax filing forms of the person requesting financial assistance or if the person requesting financial assistance is included as a dependent on the income tax filing forms of another household member.) The following applications can serve as a substitute WHS application:

- Friends in Need
- Rural Health Consortium
- Appalachian Mountain Project Access (AMPA),
- Healing Hands

Household income is defined as all wages, salary, tips, government benefits, pensions, support/alimony payments, roomer/boarder payments, work release checks, unemployment benefits, military allotments, regular contributions, and in-kind contributions.

In addition to household income, **assets** of the applicant will be considered including: property other than primary residence, life insurance if the cash surrender value exceeds $10,000; retirement benefits in excess of $10,000; other accounts such as certificates of deposit, money market accounts, stocks and savings accounts in excess of $2,000. The charity care approval process will also include steps to insure that third party government assistance is not available to the patient (TennCare, Virginia Medicaid, Medicare Disability, etc).

COPY

Poverty Guidelines:

If the patient's or guarantor's income is below 200% of the poverty guidelines, the application will be approved for a 60 -100% write-off. Applications with income over 200% of the federal poverty guidelines will be denied assistance unless the Charity Care Committee or Administration approves otherwise based on extenuating circumstances.

These special circumstances could include patients who are between 200% and 400% of the federal poverty guidelines but whose account balance (after all insurances have processed or uninsured discount is applied) is equal to or greater than 50% of the patients total annual household income. The maximum a patient would be expected to pay to settle an account balance would be 15% of annual household income.

In addition to the above process, patient accounts which are unresolved are analyzed by a third party. The third party scores the accounts to determine if the patient qualifies for Presumptive Charity Care. If the patient qualifies, the account will be written off as Presumptive Charity Care.UNINSURED:

UNINSURED: Regardless of a patient's income level, all patients who are uninsured will be entitled to the Uninsured Discount of 60%.

CHARITY CARE: Items that will not be discounted under Charity Care policy are:

- Hearing Aids
- Healthy Hearts
- Cosmetic Surgery
- Elective Procedures, defined by the WHS that are not deemed medically necessary.
- Does not apply to already discounted / negotiated services (eg. DOTS, CDLs)

- Evaluation and Management office CPT codes (place of service 11) are excluded from Charity Care discounts (99201-99215, 99381-99397, 99241-99245)
- Any account balances associated with Out-of-Network services
- Special promotions (eg, flu vaccine day, PSA test weekend, Mammography)
- Presumptive Charity Care
- HVMC Indigent clinic charges and related referrals to clinics will not be excluded from our charity policy.

For charity accounts, the uninsured discount will be reversed and the entire account balance will be adjusted off and classified as charity care (Bad Debt)

The applicant will be notified in writing of the committee's decision.

Scope:

All Wellmont Hospitals and Clinic Facilities

Regulatory Agency Standard(s):

N/A

History/Supersedes:

Replaces Financial Assistance/Charity Policy

COPY

Attachments:

No Attachments

Committee	Approver	Date
	Doris Young: Corporate Compliance Assistant	03/2011
	Christopher Spencer: VICE PRESIDENT REVENUE CYCLE	02/2014
	Alice Pope: EXECUTIVE VICE PRESIDENT AND SYSTEM CFO	04/2014
System Policy Task Force/Oversight Committee	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	08/2014
System PolicyStat Administrator	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	08/2014
	Christopher Spencer: VICE PRESIDENT REVENUE CYCLE	12/2014
	Alice Pope: EXECUTIVE VICE PRESIDENT AND SYSTEM CFO	12/2014
System Policy Approval & Oversight Committees	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	01/2015
	Christopher Spencer: VICE PRESIDENT REVENUE CYCLE	04/2015
	Alice Pope: EXECUTIVE VICE PRESIDENT AND SYSTEM CFO	09/2015
System Policy Approval & Oversight Committees	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	10/2015

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Exhibit 8.5

Attachment B

Wellmont's Charity Care Policy and Related Policies

Wellmont Health System

Effective:	*11/1993*
Approved:	*10/2015*
Last Revised:	*10/2015*
Custodian:	*Janet Hazlewood: DIRECTOR QUALITY ACCRED/RISK MANAGEMENT*
Policy Area:	*Risk Management*
Regulatory:	
Applicability:	*Wellmont Health System*

Patient Bill of Rights

Policy Statement:

A. Wellmont hospitals, as healthcare institutions, have the responsibility to patients, staffs, medical staffs, affiliated organizations, and the communities we serve to conduct business and patient care operations within a consistent ethical framework as defined by our mission, vision, values and related policies and documents.

B. The ethical framework within which the staffs and physicians of Wellmont hospitals conduct all aspects of patient care and business operations is provided by the principles defined in our mission, vision and values:

1. **Mission:** We deliver superior health care with compassion.
2. **Vision:** We will deliver the best health care anywhere.
3. **Values:**
   a. Integrity
   b. Respect
   c. Compassion
   d. Empowerment
   e. Innovation

COPY

Policy:

WELLMONT HEALTH SYSTEM PATIENT RIGHTS AND RESPONSIBILITIES

The Wellmont Health System advocates these patient rights and responsibilities without regard to gender or cultural, economic, educational or religious background or the source of payment for care and follows ethical behavior in its care, treatment, services and business practices. All Wellmont Health System personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patient rights.

As a patient you have the right to:

- Know and experience your rights and become informed of your rights as a patient in advance of, during, or when discontinuing the provision of care.

- Considerate, respectful, supportive care for your physical, psychological, social, emotional concerns and respect for your personal values and beliefs in an environment that preserves dignity and contributes to a positive self-image.
- Reasonable access to and continuity of your care
- Information concerning your diagnosis, condition, course of treatment including potential benefits and risks, and prospects for recovery including unanticipated outcomes, in terms that you can understand
- To be educated and participate actively in the development and implementation of the care plan and safe delivery of care including appropriate management of pain
- Participate in ethical issues that come up during your care and have such issues addressed
- Have a designated family member/representative participate in informed decisions about your health care, when appropriate
- Exclude any or all family members from participating in your care (this does not apply to unemancipated minors)
- Receive visitors and have a support person with you for emotional support
- Receive information regarding advance directives and generate advance directives and have them followed within the limits of the law and to receive medical care even if you do not have advance directives
- Express your wishes about foregoing, withholding or withdrawing resuscitative services and/or life sustaining treatments
- Have a family member or representative of choice, and personal physician notified of admission to the hospital with your consent
- Appropriate assessment and management of pain
- Know the names of your physicians and caregivers and their professional titles and status
- Request a change of health care provider or second opinion if desired
- Agree to and refuse treatment to the extent permitted by law and to be informed of the benefits, possible consequences of such action and of alternative treatments
- Be fully educated about the discomforts/risks/benefits, and to consent or refuse to participate in experimental treatment/research and also receive information about alternatives that might be helpful. You may refuse to participate and still receive other services. When participating in research investigation and clinical trials your rights shall be protected and respected and you will be given an explanation of the procedures to be followed
- Personal privacy and to receive care in a safe/secure environment
- Agree to and refuse for your picture to be used for any reason other than providing care
- Express spiritual beliefs and cultural practices and wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatments
- Express concerns/dilemmas/grievances about your care to a nurse/employee or if needed to a member of management and to have these issues addressed and if possible resolved
- Confidentiality of all communications and your clinical records and access to the information in your medical record within the limits of the law
- Information provided with sensitivity regarding autopsy, organ and other tissue receipt/donation
- Freedom from all forms of abuse/harassment, neglect and exploitation
- Explanation of all charges for service and items on your bill
- Reasonable response to a request for services within the capacity of the health care facility
- Information about your continuing health care needs/options and planning for care after leaving the hospital as appropriate
- Information about rules and regulations affecting your care or conduct.

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- Access to protective services (guardianship, advocacy services, conservatorship, adult and child protective services etc.)
- Pastoral and spiritual care
- Access to oral and written communication in your preferred language for discussing healthcare, such as, translators or special equipment for communication, if needed.
- When communication is restricted you and/or your family will be included in the process, including therapeutic effectiveness of the restriction.
- Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff
- Request and be informed of the existence of business relationships among the hospital, educational institutions, other health care providers or payors that may influence your treatment and care
- Be informed when the hospital cannot provide the care you request and be informed of your needs and alternatives for care
- Be transferred to another organization if necessary and medically advisable and the transfer is acceptable to the receiving organization

As a patient you are responsible to:

- Provide accurate and complete information regarding past and present medical problems, medications, and other matters pertaining to your health
- Follow medical instructions and health advice and discuss desired changes or concerns about your ability to comply
- Accept the consequences of your actions if you refuse treatment or do not follow instructions or advice
- Report changes in condition or symptoms or concerns regarding your care promptly
- Notify your caregiver if you do not understand information about your care or treatment or what is expected of you
- Act in a considerate, cooperative manner and respect the rights of others
- Choose whether you wish to be treated at a Wellmont Health System facility. For a medical non emergency, if your managed care organization does not cover the charges, you would be responsible for paying the bill
- Assure that your financial obligations for health care are fulfilled promptly
- Follow the rules and regulations of the health care facility
- Keep appointments and notify the hospital or physician if you cannot do so.
- Respect your personal property and that of other persons in the hospital and the hospital property
- Report any concerns regarding your care and/or any unexpected changes in your condition to the responsible practitioner.
- Ask questions when you do not understand what you have been told about your care or what you are expected to do.
- **Special Needs Patients**
  - ***If you feel special assistance is needed contact the Admissions Department, Case Management or Nursing Staff.***

Additionally, patients are encouraged to become active, involved and informed participants on the health care team. To help prevent health care errors, patients are urged to "Speak Up:"

Speak up if you have questions or concerns, and if you don't understand, ask again. It's your body and you have a right to know.

Pay attention to the care you are receiving. Make sure you're getting the right treatments and medications by the right health care professionals. Don't assume anything.

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Educate yourself about your diagnosis, the medical tests you are undergoing, and your treatment plan

Ask a trusted family member or friend to be your advocate.

Know what medications you take and why you take them. Knowledge of your medications helps prevent medication errors.

Use a hospital, clinic, surgery center, or other type of health care organization that has undergone a rigorous on-site evaluation using established state-of-the-art quality and safety standards, such as that provided by The Joint Commission.

Participate in all decisions about your treatment. You are the center of the health care team

Wellmont Health System hospitals are accredited by Joint Commission on Accreditation of Healthcare Organizations. You may contact The Joint Commission at:

- The Joint Commission
- One Renaissance Blvd.
- Oakbrook Terrace, IL 60181
- Phone: 1-800-994-6610

In addition to the "Speak Up" reminders noted above, the American Hospital Association encourages patients and their families to follow the "Five Steps to Safer Health Care" listed below:

A. 1. **Ask questions if you have doubts or concerns.** Make sure you understand the answers. Choose a doctor you feel comfortable talking to. Take a relative or friend with you to help you ask questions and understand the answers.

2. **Keep and bring a list of ALL the medicines you take.** Give your doctor and pharmacist a list of all the medicine that you take, including non-prescription medicines. Tell them about any drug allergies you may have. Ask about side effects and what to avoid while taking the medicine. Read the label when you get your medicine, including all warnings. Make sure your medicine is what the doctor ordered and know how to use it. Ask the pharmacist about your medicine if it looks different than you expected.

3. **Get the results of any test or procedure.** Ask when and how you will get the results of tests or procedures. Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail. Call your doctor and ask for your results. Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.** Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from. Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. **Make sure you understand what will happen if you need surgery.** Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation. Ask your doctor, "Who will manage my care when I am in the hospital?" Ask your surgeon: Exactly what will you be doing? About how long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

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Scope:

All Wellmont Departments

History/Supersedes:

supersedes BRMC-AD-911-0003-PO, HVMC-AD-911-0046-PO, HCMH-W-SY-901-0056-PO, WHCH-W-SY-901-0056-PO, WLPH-W-SY-901-0056-PO.

Regulatory Agency Standard(s):

The Joint Commission Rights and Responsibilities of the Individual standards

CMS 42 CFR 482.13 - Condition of participation:Patient's Bill of Rights

Reference:

N/A

Attachments:

Patient Compliant and Grievance Resource

Committee	Approver	Date
System Safety Committee	Marsha Helton: RN; Director Clinical Quality/Patient Safety	09/2012
	Tracey Moffatt: EXECUTIVE VP AND CHIEF OPERATING OFFICER	09/2012
	Margaret Denarvaez: PRESIDENT WHS	09/2012
	Doris Young: Corporate Compliance Assistant	09/2012
Risk Management SLDS Team	Melissa Mccall-Burton: DIR QUAL/RISK/MED STAFF	10/2015
	Gary Miller: EXECUTIVE VICE PRESIDENT, CHIEF GENERAL COUNSEL	10/2015
System Policy Approval & Oversight Committees	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	10/2015

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Exhibit 8.5

Attachment C

Wellmont's Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy

Wellmont Health System

Effective:	*04/2014*
Approved:	*04/2014*
Last Revised:	*04/2014*
Custodian:	*Sharon Webb: ADMINISTRATIVE SECRETARY*
Policy Area:	*Single Billing Office*
Regulatory:	
Applicability:	*Wellmont Health System*

Wellmont Health System Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy

Policy Statement:

It is the policy of Wellmont Health System to engage in routine collections of patient debt that is allowable and consistent with federal, state and local laws; transfer accounts in accordance with standard operating procedures to a collection entity separate from Single Billing Office, and list as bad debt without regard to patient type or financial class.

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Policy:

The amounts uncollectible from non-Medicare guarantors are to be charged off as bad debt in the accounting period in which the accounts are deemed to be non-collectable. For Medicare purposes allowable bad debt is defined in the Provider Reimbursement Manual (PRM)

Section 302.2 - Allowable Bad Debts - "Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate of specific deductibles and coinsurance amounts.

Section 310.2 - If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date of the first bill is mailed to the beneficiary, may be deemed uncollectible.

The following 4 criteria as outlined in Section 308 must be met;

1. *Debt is related to covered services and attributable to unpaid deductible and coinsurance amounts*
2. *Reasonable collection efforts are made*
3. *Debt is actually uncollectible when claimed as worthless*
4. *There is no likelihood of future recovery*

Process:

A. **Patient Balances**

1. **Non Medicare**

a. The Guarantor will receive 3 statements and a final notice. If the bill remains unpaid more than 90 days from the date it was first mailed to the guarantor, and reasonable collection attempts have failed, the account will be turned over to a collection agency.
    i. Day 0: Statement
    ii. Day 30: Statement
    iii. Day 60: Statement
    iv. Day 75: Final Notice Letter
    v. Day 90: Collection Letter
b. Day 90 account deemed bad debt and adjusted off as "Bad Debt".
c. Day 90 account transferred to a collection agency.

2. **Medicare**
    a. Effective April 2005, CMS issued an updated stance on uncollectible Medicare bad debts. Theycannot be claimed until closed by all collection agencies. In order to facilitate the process of collections, to appropriately manage the account receivable and to meet Medicare's bad debt audit guidelines the following procedures will apply:
        i. Once final insurance payment is made the patient responsibility is due.
        ii. The guarantor will receive 4 statements and a final notice. This process will take approximately 121 days. The only exception will be return mail. If a correct address cannot be obtained the account will be sent to the collection agency.
        iii. Reasonable collection attempts will be made.
        iv. After 121 days have passed the account will be moved to Bad Debt. At this point, the account will be transferred to a collection services agency.
        v. When the account is deemed worthless it will be returned from the collection agency to be included in the Medicare bad debt log.

B. **Bankruptcy**
    1. When notice is received that a patient has filed for Bankruptcy, a Bankruptcy Billing Indicator is placed on accounts.
        a. Chapter 7 - All charges included in the bankruptcy are adjusted off as Bad Debt. All collection efforts are ceased
        b. Chapter 11 - All charges included in the bankruptcy are adjusted off as Bad Debt and transferred to a collection agency.
        c. Chapter 13 - All charges included in the bankruptcy are adjusted off as Bad Debt and transferred to a collection agency.

C. **Return Mail**
    1. If unable to secure a current mailing address the account will then be turned over for collections.
        a. Wellmont Health System considers the collection agency as an extension of their collection effort

D. **Small Balance Write-Off**
    1. Personal account balance less than .99 will be adjusted off as "Small Balance Write-Off".

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Reference(s):

N/A

Scope:

Wellmont Health System & Affiliates

Regulatory Agency Standard(s):

CMS Billing Manuals

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html

History/Supersedes:

N/A

Attachments:

No Attachments

Committee	Approver	Date
	Christopher Spencer: VICE PRESIDENT REVENUE CYCLE	03/2014
	Alice Pope: EXECUTIVE VICE PRESIDENT AND SYSTEM CFO	04/2014
System Policy Task Force/Oversight Committee	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	04/2014
System PolicyStat Administrator	Cheryl Perkins: PERFORMANCE IMPROVEMENT SPECIALIST	04/2014

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Exhibit 10.1

Pre-Submission Report

Better Together

Wellmont Health System | Mountain States Health Alliance

Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report

PREPARED BY

Wellmont Health System & Mountain States Health Alliance

JANUARY 2016

About Our Systems

Wellmont Health System

Wellmont Health System operates six hospitals and numerous outpatient care sites, serving communities in Northeast Tennessee and Southwest Virginia. Wellmont's mission is to deliver superior healthcare with compassion, and we consistently rank among the nation's best for high-quality outcomes and processes of care.

Mountain States Health Alliance

Mountain States Health Alliance operates 13 hospitals and numerous outpatient care sites across a 29-county, four-state region. Mountain States is committed to its mission of bringing loving care to healthcare – and we passionately pursue healing of the mind, body and spirit to meet the needs of the individuals and communities in our region.

A Letter to the Community from Our Boards

In April 2015, we jointly announced our desire to create a new approach to healthcare in our region by bringing our two organizations together to form a new, integrated and locally governed health system. We have been working diligently since then, meeting with both internal and external stakeholders and engaging in a meticulous process to be sure that we're taking the right path as we prepare to seek approval to come together.

Most importantly, we've had countless conversations with individuals throughout the community who are eager to see the health status of our region improve, and they're excited about what the future holds for these counties we call home.

The document you now hold is an important step in the final approval process, and we could not be more excited about the possibilities it represents. This report and the applications that will follow it are part of what sets our vision apart from the traditional mergers that are so common in the healthcare industry today. An important difference is that we're involving you, the public, and making enforceable commitments to create an organization that has a measurable, positive impact on our region.

We've put a lot of careful thought into the commitments in this document, because we know that the decisions we make together today are going to impact our children, our grandchildren and even our great-grandchildren for many generations to come. That's another reason we believe that joining together is the right thing to do, because it allows us to keep governance of our local healthcare here at home. There will always be difficult decisions to make as we continue to navigate the changing and challenging world of health care, and we would rather those decisions be made by people who live here and have a personal stake in the outcomes. A great many of you have told us that this is your wish, as well.

We are your neighbors, and we hear your voice. We will be accountable not only to the states that will supervise us, but also to you, our friends and family. We take seriously our responsibility to act in the best interest of the communities we serve.

As you read through the commitments outlined in this report, we hope you will feel – and share – our enthusiasm for the great things we can do together to help our region thrive. Thank you for your continued support, and know that we value your thoughts and opinions. Our process is not complete without your input, so please let us know your thoughts on this report or any other subject by communicating with us at **www.BecomingBetterTogether.org**. We hope that the more we share about our vision, the more we will all agree that we truly are better together.

Sincerely,

Bart Hove, *President and CEO*
Wellmont Health System

Roger Leonard, *Chair*
Wellmont Health System
Board of Directors

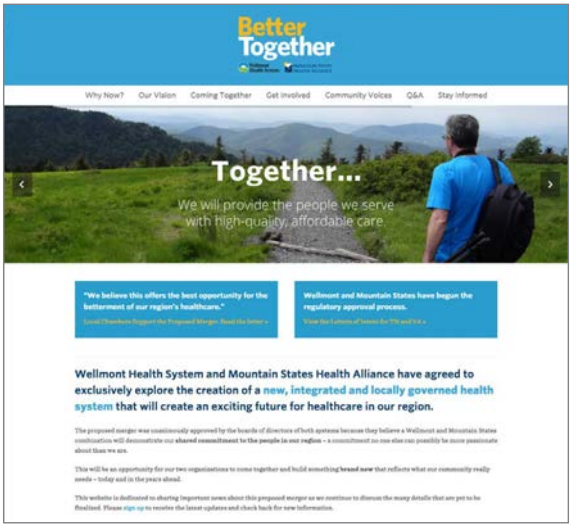
Alan Levine, *President and CEO*
Mountain States Health Alliance

Barbara Allen, *Chair*
Mountain States Health Alliance
Board of Directors

Purpose of the Report: Community Engagement and Feedback

This Pre-Submission Report provides the context for the proposed merger of Wellmont Health System and Mountain States Health Alliance to form a new health system (the "New Health System"), which was announced publicly in April 2015. Both systems have continuously sought to educate the public on the reasons for the merger, while also providing public opportunities for members of the community to provide input and ask questions. This transparency is not only the choice of the two organizations, it is also a requirement of the State of Tennessee and the Commonwealth of Virginia.

Wellmont and Mountain States have developed a formal process to collect community feedback. Immediately upon announcing the proposed merger, an informational website, **www.BecomingBetterTogether.org**, was created. This website provides information about the proposed merger, upcoming public events, frequently asked questions and a means to sign up for regular email updates and to submit questions. Frequently asked questions were answered on the website. The website link has been provided on collateral materials, and the public has been encouraged to ask questions. Questions may continue to be asked, and comments provided, by using the following link: **www.BecomingBetterTogether.org**



To date, Wellmont and Mountain States have participated in almost 40 scheduled community and media events that provided the public a chance to learn more and ask questions about the future of healthcare in the region. A record of the engagement to-date is included in this report as Attachment I. In addition, dozens of employee meetings and communications have been conducted throughout both organizations over the course of the last nine months, allowing substantive opportunities to ask questions and make comments.

Physician input has also been sought through medical staff and independent physician group meetings. In addition, both independent community physicians and physicians employed by each system have prominent leadership roles on the Integration Council and the Joint Board Task Force responsible for merger planning. Further venues for physician input are engrained in the original agreement between the two systems, which stipulates there will be a Clinical Council led by physicians, which reports through the Quality Committee of the new Board of Directors. It is the vision of the New Health System that physician input will be crucial to clinical and service-related issues after the completion of the merger. For more information on the Certificate of Public Advantage and Virginia Cooperative Agreement statutes and regulations, please see the following links:

TENNESSEE COPA STATUTE (TCA §68-11-1301 et seq.)
TENNESSEE COPA REGULATIONS
VIRGINIA COOPERATIVE AGREEMENT STATUTE
VIRGINIA COOPERATIVE AGREEMENT REGULATIONS

The Certificate of Public Advantage and Cooperative Agreement Process

This merger is contingent on the granting of a Certificate of Public Advantage by the State of Tennessee and a Cooperative Agreement with the Commonwealth of Virginia ("State Agreements"). Once granted, the State Agreements authorize Wellmont and Mountain States to merge and provide the framework for ensuring active supervision of the New Health System's compliance with these agreements and the mutually agreed enforceable commitments that benefit the community. Active supervision ensures that the benefits of the merger continue to outweigh any potential disadvantages and that the Tennessee and Virginia policies underlying the issuance of the State Agreements are fulfilled. The states require that the New Health System maintain a Plan of Separation so that if the benefits of the merger no longer outweigh the disadvantages, the plan can be operationally implemented without undue disruption to essential health services.

Each state separately evaluates the potential benefits of its State Agreement, considers whether one or more of the following benefits might result from the State Agreement, and assesses whether the benefits outweigh possible disadvantages. These benefits generally include:

- Enhancement of the quality of health and healthcare in the region
- Preservation of healthcare facilities in geographical proximity to the communities traditionally served by those facilities
- Gains in the cost-efficiency of services provided by the hospitals involved and prices paid by consumers
- Improvements in the utilization of hospital resources and equipment
- Avoidance of duplication of hospital resources

Background & Vision for the New Health System

Wellmont and Mountain States have served the health needs of residents in Northeast Tennessee and Southwest Virginia for decades. Both have invested in creating locally governed not-for-profit health systems to meet the unique needs of the region by providing a comprehensive array of services regardless of an individual's means of payment or ability to pay.

To move forward, the two systems have developed a comprehensive process to guide the design of the New Health System based on a shared vision, thoughtful analysis of current and future community health needs, significant feedback from the community, and oversight by both the State of Tennessee and Commonwealth of Virginia.

The vision of the proposed merger, which has been adopted by both Boards of Directors, sets forth that the New Health System will:

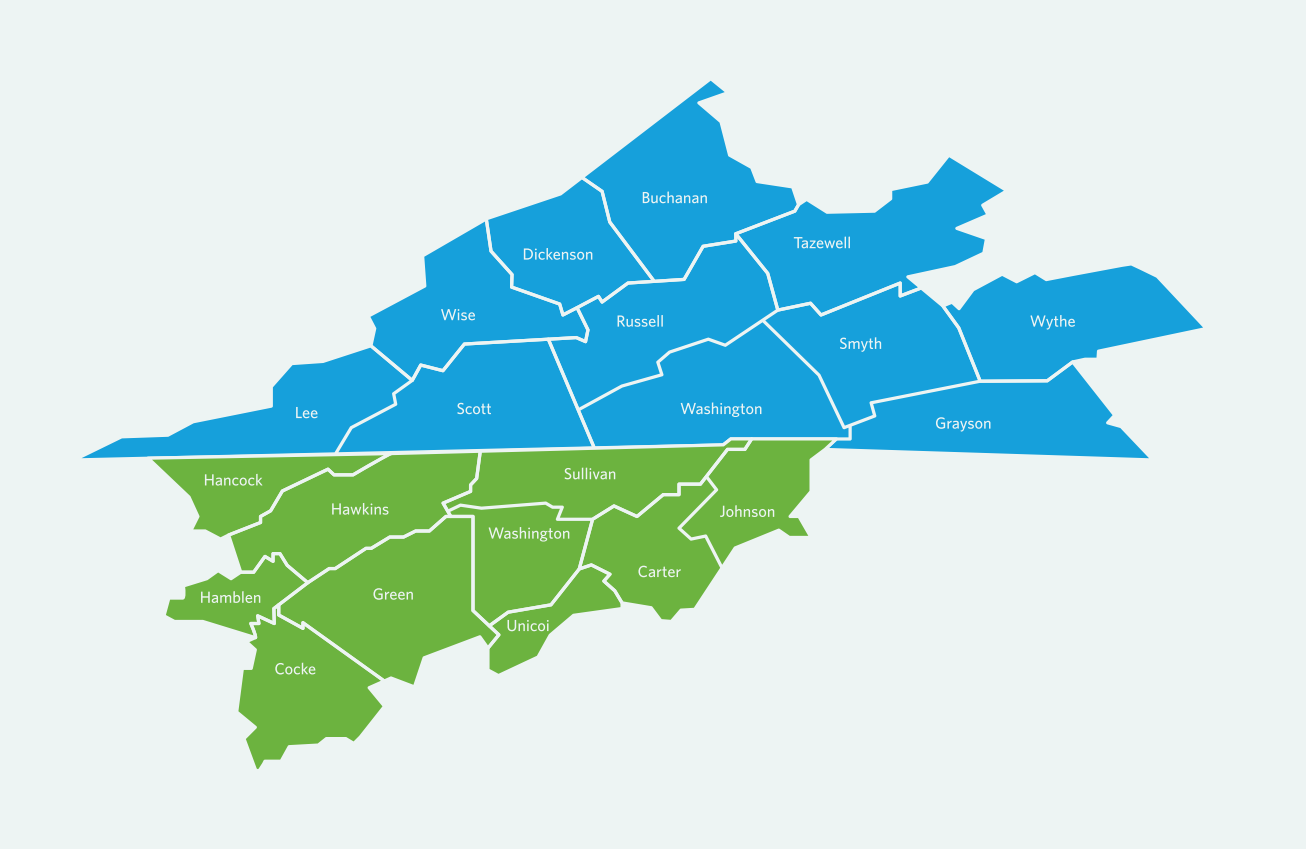
- Establish new unifying mission, vision, and values statements that honor our heritage and charter our future;
- Be one of the strongest health systems in the country, known for outstanding clinical outcomes and superior patient experiences;
- Be one of the best health system employers in the country 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 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; and
- Establish innovative philanthropic partnerships for healthcare advancement

The New Health System will have a new name and be governed by a new sixteen-member Board of Directors. This new Board initially includes: six (6) members appointed by Wellmont, six (6) members appointed by Mountain States, the Executive Chairman/President, the Chief Executive Officer, two (2) jointly appointed members not currently associated with the governance of either system, and the President of East Tennessee State University as an ex-officio nonvoting member. The New Health System will be managed by a senior executive team with representatives initially selected from each organization: Executive Chairman/President Alan Levine from Mountain States, Chief Executive Officer Bart Hove from Wellmont, Chief Operating Officer Marvin Eichorn from Mountain States and Chief Financial Officer Alice Pope from Wellmont.

Service Area and Facilities

The New Health System will primarily serve the following counties: Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee and Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise and Wythe in Virginia.

All Wellmont and Mountain States inpatient, outpatient, clinic, and support facilities will be included in the Tennessee COPA and Virginia Cooperative Agreement with the exception of those where the health systems do not own a controlling interest. For a more detailed listing, please see Attachment II.



Rationale for the Merger

For more than a year, the Boards of Directors of Wellmont and Mountain States each deliberated on how to best navigate a challenging environment for hospitals. This environment has resulted in the closure of more than 60 rural hospitals in the nation since 2010.[1] In addition, hundreds of local hospitals have been acquired by large multistate health systems or for-profit healthcare companies that lack deep-rooted understanding of local community health needs and have fiduciary obligations unaligned with the health of the local economy.

The challenges faced by our local systems contribute uniquely to the rationale for the proposed merger. There is a high concentration of services in our region with the third lowest Medicare Wage Index in the nation – leading to substantially lower reimbursement than peer hospitals in other states and in Tennessee for the same services. These challenges are intensified by a high proportion of Medicare, Medicaid, and uninsured patients. The two health systems have expensive, unnecessary duplicative healthcare resources that are allocated inefficiently; a merger would enable elimination of unnecessary duplication to capture large cost savings and realign resources to improve access and quality. In addition, there is projected downward pressure on reimbursement by government payers as costs for labor and supplies continue to grow. Collectively, we serve a region with one of the highest inpatient use rates; moreover these rates are projected to decline, while our fixed infrastructure costs remain. Further, there are increasing challenges with recruitment and retention of physicians as physicians retire and the newly trained physician supply does not support the demand. All of these challenges undermine the long-term sustainability of both systems and their ability to continue as independent, locally governed organizations.

Both systems are committed to maintaining the viability and vitality of regional assets in order to ensure access, manage the future costs of healthcare for local employers, and address the serious health issues affecting the communities in which we live and serve. Given the multitude of challenges faced by the two systems, combined with the consolidation that is occurring throughout the industry among hospitals, physician groups, insurance companies and even health information technology companies, it is clear that neither Wellmont Health System nor Mountain States Health Alliance will be able to remain independent moving forward. Given this reality, two options exist: merge locally to capture large merger-specific efficiencies and quality-enhancement opportunities through an integrated, locally governed regional health system or independently merge with large healthcare systems, located and controlled from outside our region – a step that would not come close to achieving the merger-specific benefits of a Wellmont-Mountain States integration. The proposed transaction, by far, positions the region to achieve the greatest level of public advantage and cost containment.

Outside hospital systems entering the region by acquisition most likely would not be subject to substantial antitrust scrutiny and, therefore, would have little or no reason to seek a COPA or Cooperative Agreement.

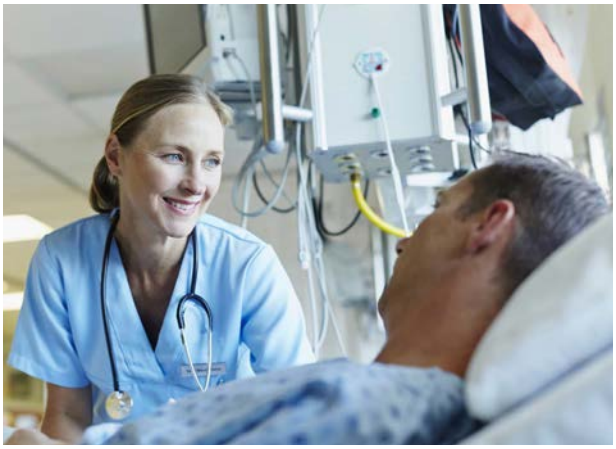
[1] University of North Carolina Sheps Center for Health Services Research, NC Rural Health Research Program. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

As such, they are free to acquire our local hospitals and take merger-related savings and jobs out of our communities without facing a requirement or local accountability to make the investments in community health that our region desperately needs. In fact, to the extent an outside system achieves any savings, most would inure to the benefit of the outside system and the dollars would most likely leave the region. Even if a system commits to spending a certain amount of capital locally, the capital is typically derived from the cash flow of the local hospital.

The boards of Wellmont and Mountain States believe the purchase of our local health systems by larger systems from outside our region is more likely to increase costs, reduce access, and negatively impact jobs.

We believe our proposed alternative is better. It is the only model that maintains local governance, provides a unique opportunity to sustain and integrate healthcare delivery for our residents into a high-quality and cost-effective system, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region, and invests those dollars in the improved health of our region while also preserving local jobs.

The process of obtaining the State Agreements, as outlined in state laws that follow a legal doctrine upheld by the Supreme Court of the United States, respects state autonomy in the regulation of its healthcare delivery system. The State Agreements permit hospitals that meet statutory requirements to consolidate in accordance with the state's policy, as long as the elements of the State Agreement are supervised by the states and provide clear public benefit. The standard acquisition by hospitals entering from "out of market" does not generally include these types of enforcement mechanisms to protect consumers or ensure enhanced community benefit.



We believe a locally governed merger by far provides the best opportunity for the local communities to retain control of the health delivery system. Our board members are local business owners and leaders, retirees and parents, all deeply affected by the decisions related to the future of the delivery system. This model provides tangible benefits for the community. When decisions are made, they are being made by people who must live with the consequence or benefit of the decision. This is the bedrock of the not-for-profit hospital model, which both systems believe is in the best interest of our region.

A major factor in the accumulation of nearly $1.5 billion of debt, and the redundant costs borne by the marketplace, has been the duplication of services and programming by Wellmont and Mountain States as separate systems. Combining the region's two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high-quality services moving forward. These efforts will produce savings that may be invested in higher-value activities in the region to help expand currently absent but necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need,

improve community health and diversify the economy into research. These new levels of development and job creation will not be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources. While consolidation will result in changes in the structure of the two organizations and displacement of some jobs, new development promises to create new job opportunities and advance the local economy. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community enhances health as well as economic well-being of the local economy, benefiting all. The benefit accrued to the community and resulting stimulus to the local economy will far outweigh any possible negative impact.

Through the State Agreements, the states of Tennessee and Virginia will be able to supervise the commitments the New Health System is making, which are described more fully herein. Further, the reinvested savings associated with the proposed merger provide compelling evidence that the resulting community benefit and public advantage will be substantial. These investments are described in more detail throughout the report. As examples, the New Health System will:

Invest not less than $75 million over ten years in population health improvements, committed through a regional ten-year plan

Invest not less than $140 million over ten years to expand mental health, addiction recovery, and substance abuse prevention programs; develop both healthcare- and community-based resources for children's health across the region; meet regional physician needs and address service gaps and preserve and expand rural services and access points

Invest not less than $85 million over ten years to develop and grow academic and research opportunities, support post-graduate healthcare training, and strengthen the pipeline and preparation of nurses and allied health professionals

Invest approximately $150 million over ten years to facilitate the regional exchange of health information among participating providers and to establish an electronic health record system within the New Health System that ensures a common platform and interoperability among its hospitals, physicians, and related services

Major Health Issues and Trends

According to the 2015 America's Health Rankings, Tennessee ranked 43rd and Virginia 21st in the U.S. for overall public health.[2] The county-level data in Table I, however, demonstrate that Northeast Tennessee and Southwest Virginia counties — the areas we serve — perform far worse than their state averages and are in fact among the unhealthiest counties in the United States. Based on County Health Rankings data published by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, the counties served by Wellmont and Mountain States rank among the worst in Virginia and Tennessee in several categories, notably in tobacco use, death due to drug poisoning and obesity.

Table I: Select Measures from County Health Rankings

Service Area Health Rankings By State, County or City	Overall State or County Health Rank	Percentage of Adults Reporting Fair or Poor Health	Percentage Of Adults That Are Obese	Percentage of Adults Who Are Currently Smokers	Percentage of Children In Poverty	Drug Poisoning Mortality Rate per 100,000 Population
Tennessee	**43rd**	**19%**	**32%**	**23%**	**27%**	**16**
Carter	48/95	23%	29%	31%	34%	20
Cocke	88/95	27%	31%	21%	41%	21
Greene	59/95	21%	32%	29%	30%	22
Hamblen	54/95	26%	30%	23%	29%	27
Hancock	93/95	29%	30%	40%	45%	42
Hawkins	64/95	26%	35%	26%	31%	26
Johnson	44/95	26%	31%	28%	38%	11
Sullivan	36/95	22%	33%	26%	28%	17
Unicoi	68/95	26%	30%	23%	29%	24
Washington	19/95	19%	31%	24%	24%	17
Virginia	**21st**	**14%**	**28%**	**18%**	**16%**	**9**
Buchanan	132/133	29%	29%	30%	33%	37
Dickenson	130/133	31%	29%	32%	28%	53
Grayson	74/133	20%	32%	22%	29%	Not reported
Lee	116/133	29%	29%	25%	39%	14
Russell	122/133	29%	35%	25%	26%	32
Scott	114/133	23%	34%	28%	27%	14
Smyth	123/133	29%	31%	22%	26%	15
Tazewell	133/133	29%	30%	21%	23%	37
Washington	82/133	19%	32%	24%	21%	13
Wise	129/133	24%	32%	33%	28%	38
Wythe	85/133	27%	30%	24%	22%	18

University of Wisconsin Population Health Institute. County Health Rankings 2015.
Accessible at www.countyhealthrankings.org

[2] America's Health Rankings 2015 Annual Report.
http://www.americashealthrankings.org/VA and http://www.americashealthrankings.org/TN

Commitment to Improve Community Health

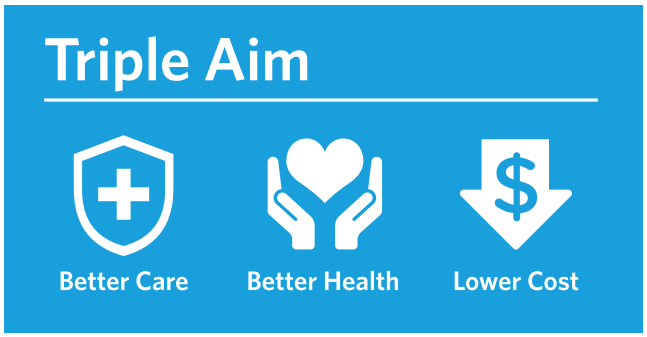
Wellmont and Mountain States are committed to creating a new health system designed to improve community health. To accomplish this, the New Health System will commit to pursuing health improvements aligned with goals contained within the current Tennessee State Health Plan, the Virginia Health Innovation Plan (including the Lieutenant Governor's Quality, Payment Reform, and HIT Roundtable and Virginia's Plan for Well Being) and with regional collaborative health improvement goals such as those set forth in Healthier Tennessee and the Blueprint for Healthy Appalachia. Additional local stakeholder input is being compiled by four Community Health Work Groups (mental health and addiction, healthy children and families, population health and healthy communities, and research and academics) organized by Wellmont and Mountain States.

All of these efforts recognize that income, education, family and community support, personal choices, genetics and the environment are key drivers of individual and community health and well-being. As the 2014 Tennessee Health Plan states, "We know that healthcare alone cannot make major improvements in population health. To make significant improvements, we need to understand what 'being healthy' and 'staying healthy' mean, and how to encourage our entire society to value health. In other words, we need to build a culture of health."

Yet each year, more of each employee paycheck, employer payroll and government budget is consumed by healthcare services, and less is invested in education, wage and job growth, public safety and other important investments. This is despite the fact the Institute of Medicine estimates that 30% of all healthcare service spending is wasted due to factors such as unnecessary and duplicative services, administrative burden, inefficient services, high prices, fraud and missed prevention opportunities.[3]

Hospitals and doctors have traditionally been paid to treat sick and injured patients. But Mountain States and Wellmont believe that redirecting savings identified from the merger into best-practice interventions aimed at the underlying causes of poor health in vulnerable populations will offer our best opportunity to improve the health of the overall population we serve. This requires a new approach that goes beyond the four walls of the health system and requires community collaboration and focus on a limited number of key problems and associated interventions. This necessitates both leadership and investment by the New Health System in partnership with many community stakeholders.

Fortunately, the region is primed for collaborative action to improve health in the form of a Regional (Northeast Tennessee-Southwest Virginia) Accountable Care Community (ACC). Successful ACC development requires multiple public and private stakeholders to commit to working collaboratively to advance the Triple Aim (better care, better health, and lower cost) in this region and to share the responsibility for the health of the community.



[3] IOM (Institute of Medicine). 2010. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press. At Preface xvi and p.50

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. Consistent with federal objectives to better engage communities, in the Commonwealth of Virginia, the creation of Accountable Care Communities (ACCs) is an important strategy of Virginia's State Innovation Model Design awarded by the federal government.

To develop a comprehensive plan for the region which the New Health System can provide financial and other support, we propose adopting a community-driven strategic planning process between the New Health System, the state, and local Department of Health and an organized community of stakeholders, which will prioritize program strategies to meet defined community health improvement goals. This process would be guided by the National Association of County and City Health Officials' (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) framework displayed to the right.

Analyzing the most current output of the Tennessee State Health Plan, the Virginia Health Innovation Plan, Healthier Tennessee and the Blueprint for Healthy Appalachia, and the four Community Workgroups, Mountain States and Wellmont have identified as a starting point four key strategic issues in which we believe the New Health System may make regional investments using redirected savings from the merger or whereby the merger itself aids in the achievement of these goals.

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.

The New Health System would commence the population health improvement process with the preparation of a comprehensive community health improvement plan, identifying 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 East Tennessee State University. The funding may be committed to the following initiatives, as well as others as determined based upon the 10-year action plan for the region.

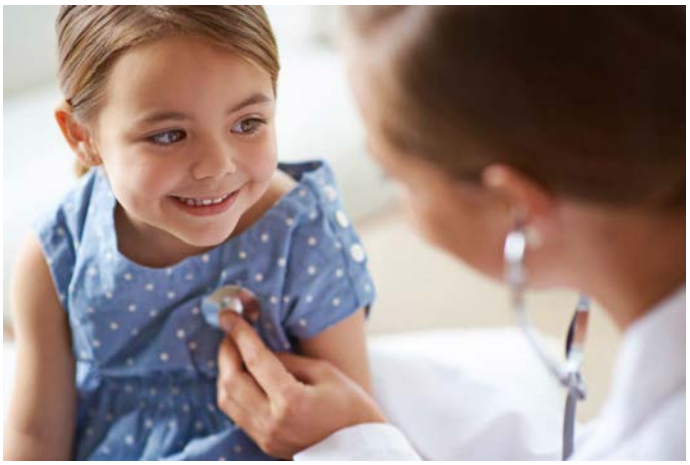
- **Ensure strong starts for children** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the 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 overprescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs.
- **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 New Health System will also provide financial support to develop and sustain an Accountable Care Community effort across state lines for our region that will help address these and other issues identified through the community health improvement plan.

A Community Health Work Group held in the fall of 2015

Enhanced Healthcare Services

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.



Northeast Tennessee and Southwest Virginia are also victims of a flawed and antiquated federal funding program for Medicare, which depresses the reimbursement for our region relative to peer hospitals in other regions of the nation. The Medicare Wage Index adversely affects hospitals and doctors in our region, causing significant impediments to recruiting and retaining doctors, particularly specialists. For example, our hospitals are compensated at approximately 73 percent[4] of the average wage index for treating the same patient, with the same condition, for which a treating hospital in San Jose, California, would be compensated at 178 percent of the average wage index.[5] In the aggregate, this difference costs our region tens of millions of dollars annually in lower reimbursements, and has a substantial impact on physicians as well.

Providing these services is important and expensive. Why should rural families be required to expect less when it comes to access? Niswonger Children's Hospital, for example, continues to work to attract and support many subspecialties, but many families still travel significant distances to receive care. It is all too common that a child's illness forces families to split apart long-term or creates job loss as one parent must work while the other travels as a full-time caregiver. We don't believe these disparities should prevail and are prepared to make investments to ensure the most vulnerable have improved access.

Families and individuals suffering from the prescription drug addiction epidemic and other substance abuse disorders face even more difficult challenges. Funding has not kept up with needs and our local systems are overwhelmed. Families again face the difficult choice of splitting apart as loved ones must travel long distances to receive services, or even worse, can't find services at all or face long waits.

The proposed merger will produce savings which will be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise couldn't be supported in a region of our size, geography and population density. In addition, the proposed merger will provide a unique opportunity for the New

[4] This figure represents the average across Johnson City, TN and the Kingsport-Bristol-Bristol, TN-VA MSAs.

[5] CMS Fiscal Year 2015 Wage Index Table, available here: https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/wageindex.html

Health System to work with academic institutions in the region to increase training and recruitment of physicians and allied health professionals. Developing our own workforce connected with the region and likely to stay here long-term provides a strong supplement to recruitment efforts for other top-tier doctors, nurses and allied health professionals from other parts of the country.

The New Health System commits to spending at least $140 million over ten years pursuing specialty services, outlined as follows, which otherwise could not be sustainable in the region without the financial support. Partnerships with academic institutions will enable research-based and academic approaches to the provision of these services.

- Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
- Develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements.
- Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.
- 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.
- 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. We expect the combined system to facilitate this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding.

Expanding Access and Choice

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.

In the U.S., rural hospitals and healthcare providers are at increasing risk. According to the University of North Carolina Sheps Center, 61 rural hospitals have closed since 2010, including six in Tennessee and one in Virginia.[6] Wellmont and Mountain States each make substantial investments in order to maintain access to health care services in their rural communities.

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. This does not include significant additional capital investments.

Mountain States Rural Hospitals:

- Smyth County Community Hospital
- Russell County Medical Center
- Unicoi County Memorial Hospital
- Johnson County Community Hospital
- Dickenson Community Hospital
- Norton Community Hospital
- Johnston Memorial Hospital

Wellmont Rural Hospitals:

- Hawkins County Memorial Hospital
- Hancock County Hospital
- Lonesome Pine Hospital
- Mountain View Regional Medical Center

For the reasons discussed above, it will be increasingly difficult to continue sustaining these facilities over the long-term without the savings the proposed merger would create. Protecting and increasing patient choice is important to Mountain States and Wellmont. By integrating our two systems, we will help ensure that our communities continue to have access to the care they need close to home and that care options are expanded rather than reduced. Currently, more than one-quarter of inpatient admissions in the region occur at hospitals other than those owned by the two systems. Most outpatient medical services are actually delivered outside the two systems by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, long-term care services, skilled nursing, physical therapy, occupational therapy, pharmacy, counseling, and surgery centers. Wellmont and Mountain States are required to ensure patient choice when selecting these services and will continue these policies as a merged organization.

[6] University of North Carolina Sheps Center for Health Services Research, NC Rural Health Research Program. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

After the merger, patient choice of hospitals will increase. Currently, some patients are limited to either Wellmont or Mountain States hospitals because of constraints in insurance networks. Similarly, many doctors are limited to practice in certain hospitals by contract. In each of these examples, patient choice is limited in the current environment. As another example, in some areas of the region, patients are often referred to hospitals farther away than more local hospitals, because the closer hospitals are part of the competing system. This inconvenience exists because of the continuum of care and physician relationships that arise between the facilities and because of transfer patterns from community hospitals to tertiary centers within the same system. Through the proposed merger, a more comprehensive and fully integrated regional network will improve patient choice and convenience, as these barriers would be removed.

Both Wellmont and Mountain States continue to value a robust and successful independent physician community. The New Health System intends to collaborate with the independent physician community where possible to build an array of service offerings which will also be accessible throughout the region.

The New Health System will invest in the development of expanded services while preserving services currently at risk through the following commitments.

- All hospitals in operation at the effective date of the merger will remain operational as clinical and healthcare institutions for at least five (5) years. After this time, the New Health System will continue to provide access to healthcare 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 healthcare and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.
- 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.
- 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.
- Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.
- Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.
- The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.

Improving Healthcare Value: Managing Quality, Cost and Service

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 healthcare cost growth for patients, employers and insurers. Currently, 126 patients for every 1,000 people in Tennessee are admitted to the hospital annually, compared to a national average of 106 admissions/1,000 population.[7] We believe a regionally integrated health system, with a comprehensive regional health information exchange, will help reduce unnecessary utilization.

The proposed merger will also result in a common platform for electronic medical records among the merging systems' combined nineteen hospitals, many employed physicians and related services and will facilitate a community health information exchange between participating community providers in the region. This will help ensure that providers have the information they need to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. Patient information will be more portable, removing barriers to patient choice and improving patient access to their own health information. A more integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services, resulting in a better patient experience and more effective and efficient care.

The merger will also allow for better clinical integration as the combined system reduces unnecessary variation in standards of care created by the simple fact that the two systems operate separately in silos and from the independent physician community. Given the significant pressure on health systems and independent physicians to deliver higher-quality care and service from Medicare and commercial payers, a unified merged system working with the independent physician community will be able to more rapidly adopt and disseminate best practices.

[7] Kaiser Family Foundation, Hospital Admissions per 1,000 Population by Ownership Type. (2013) http://kff.org/other/state-indicator/admissions-by-ownership/

The New Health System will reduce cost through improved efficiency and avoidance of waste and duplication, as well as reduce the pace of healthcare cost growth for patients, employers and insurers through the following commitments:

- For all Principal Payers,* the New Health System will reduce existing commercial-contracted fixed-rate increases by 50% for the first full contract year following the first contract year after the formation of the New Health System.
- 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%.
- The United States Government 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. For all non government 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.
- 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.
- Adopt a common clinical information technology platform as soon as reasonably practical after the formation of the New Health System.
- Participate meaningfully in a health information exchange open to community providers.
- Establish annual priorities related to quality improvement and publicly report these quality measures in an easy-to-understand manner for use by the patients, employers and insurers.
- 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 certain limitations). The New Health System would agree to resolve through mediation any disputes in health plan contracting.
- Not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.
- Not engage in "most-favored-nation" pricing with any health plans.

* "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue

Investment in Health Research and Graduate Medical Education

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 region is fortunate that Quillen College of Medicine, Lincoln Memorial University DeBusk College of Osteopathic Medicine, the Virginia College of Osteopathic Medicine, and Virginia Tech excel at educating physicians who choose to practice primary care and in rural areas.

Yet, due to financial constraints, Wellmont and Mountain States have reduced the number of residency slots in their respective systems to train these graduate physicians. Multiple studies have shown that physicians tend to locate their practice close to where they train in residency. And increasingly important to the primary care workforce are nurse practitioners and physicians assistants trained at schools such as Emory & Henry, Milligan College and the ETSU School of Nursing. Unlike physician programs, historically little funding has been available for these programs from the federal and state governments.

By investing funds generated through merger efficiencies, the New Health System will increase residency and training slots, create new specialty fellowship training opportunities, build research infrastructure, and add faculty - 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.

The New Health System will work with its academic partners 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 as outlined below – all critical to sustaining an active and competitive training program.

- With academic partners in Tennessee and Virginia, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.
- Work closely with East Tennessee State University (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.

Attracting and Retaining a Strong Workforce

Our workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for our team members. Thus, competitiveness of our pay and benefits is critical to our success. We believe certain federal policies, which have adversely affected the region's wage index, have also contributed to relocation out of market as being a primary cause of turnover. As such, the New Health System's biggest competitor for labor will continue to be regional systems located out of the immediate market. Additionally, with the Veteran's Administration hospital and services located in-region, as well as the multitude of outpatient services offered by local competition, there will be incentives for the new system to remain locally competitive for talent.

In addition, staffing is generally driven by volume. As such, if the demand for nurses, technicians and other clinical staff diminishes in the future, it will not be due to the merger but rather to the ongoing transformation of the healthcare industry. As outlined in this document, new programs to improve community health will be added and funded, all of which will need exceptional talent.

In addition to being competitive for labor, and mitigating the local impact on jobs, we are also committed to our existing workforce – our neighbors and friends who are the strength of our two organizations. We recognize that our workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for our team members. Thus, competiveness of pay and benefits is critical to the New Health System's success.

Therefore, when the New Health System is formed:

- 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 our vision to be 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.

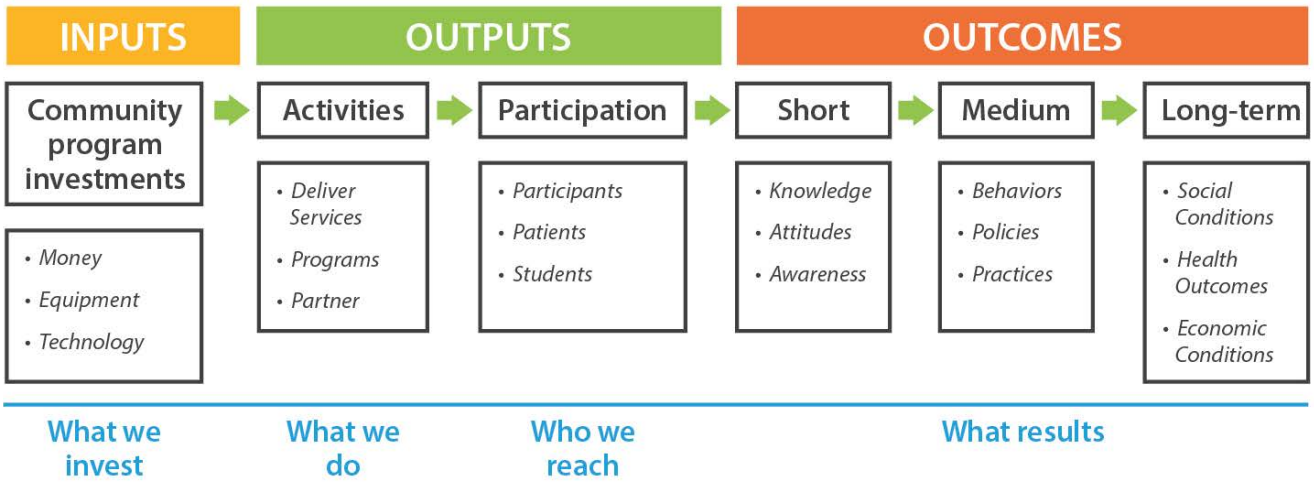
Measuring Progress

It is ultimately the goal of the New Health System to achieve the Institute of Health Improvement's Triple Aim, commonly considered the national standard for evaluation of healthcare effectiveness. As part of our applications for a COPA in Tennessee and Cooperative Agreement in Virginia, we propose that ongoing evaluation of the public advantage resulting from the merger be based on the New Health System's pursuit of the Triple Aim objectives to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of healthcare in the region.

Before the Tennessee COPA and Virginia Cooperative Agreement is granted, each State and the New Health System should agree on key health concerns as well as a limited number of long-term health outcomes for tracking within four strategic area of focus: strong starts for children, living well in the community, promoting a drug-free community and decreasing avoidable inpatient and ER use by high need-high cost uninsured individuals. As an important component of the evaluation of each application, each State will separately establish advisory groups made up of stakeholders from the area to recommend measures for consideration to objectively track the ongoing public advantage of the Tennessee COPA and Virginia Cooperative Agreement. Agreement on these specific tracking measures should serve as the guide for long-term programmatic investment by the New Health System to improve community health.

Monitoring and evaluating the continued Public Advantage produced under the Tennessee COPA and the Virginia Cooperative Agreement are essential. We are committed to close coordination with the states to establish clear processes for both monitoring and evaluation. Because evaluation of commitments regarding population health are more complex and involve many factors, both shorter-term and longer-term, we propose to use the Kellogg Foundation's Logic Model to inform the evaluation of these commitments.

Kellogg Foundation Logic Model for Evaluation



Under this model, effective measures by which we can evaluate progress towards long-term outcomes would reflect incremental investment in programs (inputs), measurements of activities and participation related to these programs (outputs), and outcomes, both short-term and medium-term. The short-term outcomes could include measurable changes in learning, such as awareness, knowledge, attitudes, skills, opinions, aspirations, and motivations. The medium-term outcomes could include measurable changes to actions such as behaviors, practices, decision making, polices, and social norms.

We believe close collaboration with the community, investment by the New Health System, and commitment to continuous and ongoing evaluation and improvement will result in positive short- and long-term outcomes that are only possible through the State Agreements.

Conclusion: Becoming Better Together

Our region has a once in a lifetime opportunity to create a long-lasting legacy of improved health by pursuing a merger between Wellmont and Mountain States. With the approvals of the states under the State Agreements, savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially through new services and capabilities, improved choice and access, managed costs and investment in both the region's economic development and its most challenging health problems.

Once the annually recurring merger related synergies have been fully realized, this merger will produce a level of annual spending to improve the health of the region equivalent to at least the spending capability of a new three-quarters of a billion dollar foundation. All of this investment will be in Northeast Tennessee and Southwest Virginia, and it will focus on improving the health, well-being, and economy of the communities we serve. Importantly, we can do all of this while maintaining local control of our healthcare system and improving the quality and cost of care.

Again, you may submit questions or make comments regarding this Pre-Submission Report using the link below:

www.BecomingBetterTogether.org

Better Together

Wellmont Health System

Mountain States Health Alliance

Appendix

ATTACHMENT I: COMMUNITY EVENTS, CORRESPONDENCE AND MEDIA INTERVIEWS

COMMUNITY EVENTS & PRESENTATIONS	
April 2, 2015	Proposed merger announcement public event
April 24, 2015	Kingsport Chamber breakfast
May 1, 2015	Bristol Tennessee/Virginia Chamber breakfast
May 6, 2015	Washington County Virginia Rotary
May 19, 2015	Johnson City Chamber Board
June 8, 2015	Kingsport Chamber Board
June 10, 2015	Southwest Virginia Health Authority
June 24, 2015	Bristol Tennessee/Virginia Chamber Board
July 7, 2015	Bristol Tennessee/Virginia Noon Rotary
July 23, 2015	Washington County Virginia Chamber Board
August 13, 2015	Elizabethton Community Round Table
August 20, 2015	Mental Health & Addiction Steering Committee
August 20, 2015	Abingdon Community Round Table
August 24, 2015	Population Health & Healthy Communities Steering Committee
August 28, 2015	Kingsport Chamber Breakfast
September 3, 2015	Virginia Department of Health Public Hearing
September 8, 2015	Healthy Children & Families Steering Committee
September 9, 2015	Mountain States Foundation Women's Luncheon
September 15, 2015	Marion Community Round Table
September 16, 2015	Johnson City Press Public Forum
September 17, 2015	Mental Health & Addiction Steering Committee
September 19, 2015	Sorensen Institute presentation
September 19, 2015	Lead Virginia
September 24, 2015	Research & Academics Steering Committee
September 24, 2015	Erwin Community Round Table
September 28, 2015	Population Health & Healthy Communities Steering Committee
September 29, 2015	Lebanon, Virginia, Community Round Table
September 30, 2015	Johnson City Rotary
October 1, 2015	Kingsport Community Round Table
October 6, 2015	Duffield Community Round Table
October 13, 2015	Healthy Children & Families Steering Committee
October 15, 2015	Bristol Community Round Table
October 16, 2015	Regional Health Care Symposium
October 20, 2015	Wise Community Round Table
October 21, 2015	Mental Health & Addiction Steering Committee

October 22, 2015	Johnson City Community Round Table
October 22, 2015	United Way of Southwest Virginia Summit
October 26, 2015	Population Health & Healthy Communities Steering Committee
October 28, 2015	Research & Academics Steering Committee
November 10, 2015	Healthy Children & Families Steering Committee
November 12, 2015	Johnson City Rotary
November 16, 2015	All Work Groups Meeting – Accountable Care Communities
November 16, 2015	Population Health Steering Committee
November 19, 2015	Mental Health & Addiction Steering Committee
December 2, 2015	Research & Academics Steering Committee
December 8, 2015	Healthy Children & Families Steering Committee
December 18, 2015	Mental Health & Addiction Steering Committee
December 18, 2015	All Work Groups Meeting – Impact of Opioids in Appalachia
See **www.BecomingBetterTogether.org** for additional upcoming events.	

COMMUNITY CORRESPONDENCE & ANNOUNCEMENTS	
April 2, 2015	Proposed merger announcement news release
April 2, 2015	Launch of www.BecomingBetterTogether.org
April 7, 2015	Integration Council announcement news release
April 16, 2015	Better Together newsletter
May 6, 2015	Better Together newsletter
May 7, 2015	Joint Board Task Force announcement news release
June 2, 2015	Better Together newsletter
June 10, 2015	Better Together newsletter
June 10, 2015	Community Health Work Groups announcement news release
August 5, 2015	Better Together newsletter
August 5, 2015	Community Health Work Groups chairs & meeting dates announcement news release
August 24, 2015	Better Together newsletter
September 16, 2015	Letter of Intent announcement news release
September 16, 2015	Better Together newsletter

MEDIA INTERVIEWS	
April 2, 2015	Proposed merger announcement interviews
April 22, 2015	Kingsport Times-News editorial board
April 22, 2015	WJHL editorial board
April 23, 2015	WCYB editorial board
April 23, 2015	Johnson City Press editorial board
May 7, 2015	WKPT editorial board
June 8, 2015	HealthLeaders Media
June 10, 2015	Community Health Work Groups announcement & interviews
June 11, 2015	Modern Healthcare interview
August 24, 2015	WJHL interview

September 16, 2015	Letter of Intent announcement interviews
September 16, 2015	Johnson City Press Forum and follow-up interviews
October 6, 2015	Interview with WCYB
October 12, 2015	Interview with the Johnson City Press
October 16, 2015	Interview with the Bristol Herald Courier
October 19, 2015	Interview with The Business Journal
November 11, 2015	Interviews with The Tennessean and WJHL
November 12, 2015	Interview with The Tennessean
November 13, 2015	Statement provided to the Johnson City Press, Roanoke Times and WKPT
November 16, 2015	Statement provided to WJHL
November 20, 2015	Statement provided to WJHL
December 1, 2015	Statement provided to WCYB
December 9, 2015	Statement provided to the Johnson City Press
December 15, 2015	Statement provided to The Business Journal and the Johnson City News & Neighbor
December 17, 2015	Statement provided to WJHL
December 23, 2015	Statement provided to The Post
December 28, 2015	Statement provided to the Johnson City Press
December 30, 2015	Statement provided to WXBQ and the Kingsport Times-News

Appendix

ATTACHMENT II: INCLUDED FACILITIES AND SERVICES

Wellmont Hospitals Wellmont's hospital operations consist of two tertiary referral medical centers: Holston Valley Medical Center in Kingsport, Tennessee, and Bristol Regional Medical Center in Bristol, Tennessee, and four wholly owned community hospitals: (1) Mountain View Regional Medical Center in Norton, Virginia, (2) Lonesome Pine Hospital in Big Stone Gap, Virginia, (3) Hawkins County Memorial Hospital in Rogersville, Tennessee, and (4) Hancock County Hospital, a critical access hospital, in Sneedville, Tennessee.	
Holston Valley Medical Center (Kingsport, TN)	Holston Valley Medical Center has been serving the Kingsport community for 80 years since opening in 1935. The 505-bed facility is staffed by more than 450 board- certified or board-eligible physicians and over 1,700 employees. Holston Valley Medical Center is a regional tertiary referral center offering a comprehensive array of inpatient and outpatient services, including advanced services and trauma services. The hospital serves as a teaching facility in partnership with schools such as East Tennessee State University and Lincoln Memorial University. It is an affiliate of Children's Miracle Network Hospitals.
Bristol Regional Medical Center (Bristol, TN)	Bristol Regional Medical Center, founded in 1925, operates in a state-of-the-art facility that opened in 1994. The 348-bed facility is staffed by more than 336 board-certified or board-eligible physicians and over 1,600 employees. Bristol Regional Medical Center is a regional tertiary referral center offering a comprehensive array of inpatient and outpatient services, including advanced services and trauma services. The hospital serves as a teaching facility in partnership with schools such as East Tennessee State University and Lincoln Memorial University. It is an affiliate of Children's Miracle Network Hospitals.

Wellmont Community Division Hospitals Wellmont community division hospitals include Lonesome Pine Hospital, Mountain View Regional Medical Center, Hawkins County Memorial Hospital, and Hancock County Hospital.	
Lonesome Pine Hospital (Big Stone Gap, VA)	A 60-licensed bed facility that has served the community since 1973. Lonesome Pine is a community hospital offering a full array of services, including emergency services and a variety of inpatient and outpatient services. The hospital serves as a teaching facility in partnership with schools such as Lincoln Memorial University. The Southwest Virginia Cancer Center, serving medical and radiation oncology patients, is part of Lonesome Pine Hospital operations. Lonesome Pine is staffed with 167 physicians, of whom 80% are board certified, and nearly 400 employees.
Mountain View Regional Medical Center (Norton, VA)	Mountain View is a 118-licensed bed full-service hospital and offers a full array of services, including emergency services and a variety of inpatient and outpatient services.. Mountain View joined Wellmont in 2007 and it is operated as a facility of Lonesome Pine Hospital under one Medicare provider number. Mountain View Regional Medical Center houses the system's only hospital-based long-term care unit. For financial reporting purposes, Mountain View is consolidated with Lonesome Pine.

Mountain View Regional Medical Center (Norton, VA)	Mountain View is a 118-licensed bed full-service hospital and offers a full array of services, including emergency services and a variety of inpatient and outpatient services.. Mountain View joined Wellmont in 2007 and it is operated as a facility of Lonesome Pine Hospital under one Medicare provider number. Mountain View Regional Medical Center houses the system's only hospital-based long-term care unit. The hospital serves as a teaching facility in partnership with schools such as Lincoln Memorial University. For financial reporting purposes, Mountain View is consolidated with Lonesome Pine. It is an affiliate of Children's Miracle Network Hospitals.
Hawkins County Memorial Hospital (Rogersville, TN)	Established in 1961, the 50- bed hospital provides care in a rural setting. Hawkins County is staffed by more than 121 board-certified or board-eligible physicians and nearly 150 employees. Hawkins County Memorial is a community hospital offering a full array of services, including emergency services and a variety of inpatient and outpatient services. The hospital is a teaching facility in partnership with East Tennessee State University.
Hancock County Hospital (Sneedville, TN)	This 10-bed facility has been designated by the state as a critical-access hospital that provides care to a medically underserved region. Hancock County was built through a partnership between the system and the Hancock County Commission. Hancock County offers emergency services and a variety of inpatient and outpatient services. Additionally, air and ground medical transportation to a larger tertiary-care facility is available should a patient require further specialization. Hancock County is staffed with 40 physicians, of whom 68% are board certified. It is an affiliate of Children's Miracle Network Hospitals.

Wellmont Corporate Entities: Ambulatory and Post-Acute Services Wellmont has been proactive in developing its capabilities across the care continuum through a variety of platforms, including medical groups, assisted living and skilled nursing care facilities, ambulatory surgery centers, urgent care facilities and other ancillary service offerings.	
Wellmont Medical Associates	A multispecialty practice group, Wellmont Medical Associates includes 135 physicians and 67 mid-levels and nurse practitioners, who deliver care in a number of fields.
Wellmont Cardiology Services	The Wellmont CVA Heart Institute offers an integrated approach with leading cardiovascular physicians and cutting-edge cardiovascular technologies and treatments. The institute includes 45 cardiovascular physicians, 23 physician assistants and nurse practitioners, and 575 cardiovascular service line employees.
Wellmont Madison House	The region's only healthcare-affiliated assisted living residence, adult day care center and short-term overnight care program. The facility provides accommodations for 29 residents with staff supervision and access to 24-hour personal assistance. Services available to assisted living residents are also available to those in the short-term overnight care program.
Wexford House (Kingsport, TN)	A 174-bed skilled and long-term care facility, Wexford House provides comprehensive skilled and rehabilitative nursing care, including: physical therapy, speech therapy, and occupational therapy; residential custodial care; respite and hospice care.

Wellmont/Health South IRF, LLC (Bristol, VA)	Joint venture between Wellmont and HealthSouth Corp., a national healthcare provider specializing in rehabilitation, to operate the Rehabilitation Hospital of Southwest Virginia in Bristol, Virginia. (25% Ownership)
Bristol Surgery Center (Bristol, TN)	Ambulatory surgery center located in Bristol, Tennessee.
Sapling Grove Ambulatory Surgery Center (Bristol, TN)	Ambulatory surgery center located in Bristol, Tennessee. The remaining ownership interest is held by various physicians. (65% Ownership)
Holston Valley Ambulatory Surgery Center (Kingsport, TN)	Ambulatory surgery center located in Kingsport, Tennessee. The remaining ownership interest is held by various physicians. (52% Ownership)
Marsh Regional Blood Center	Marsh Regional Blood Center is a wholly owned subsidiary of Wellmont that provides whole blood and other blood products to 16 hospitals and multiple cancer facilities in Northeast Tennessee and Southwest Virginia. Marsh Regional operates donor centers in Kingsport, Tennessee, and Bristol, Tennessee, and conducts mobile blood drives throughout the region.

Wellmont Corporate Entities: Integrated Support In addition to Wellmont entities that involve direct patient care and service, Wellmont has also developed strong financial and operational support capabilities through the creation of a captive insurance company, a physician hospital organization, and a philanthropic foundation, which all support the system.	
Wellmont Insurance Company SPC, LTD	Cayman captive insurance company which has been established for the purpose of insuring Wellmont's self-insured initial layer of professional liability coverage.
Highlands Wellmont Health Network	A physician hospital organization jointly owned by Wellmont Health System and Highlands Physicians, Inc. The organization includes around 1,000 physicians across the region along with Wellmont's inpatient and outpatient resources, providing a regional option for direct employer contracts and a platform for focused networks. (50% Ownership)
Wellmont Foundation, Inc.	A Tennessee nonprofit corporation and a 501(c)(3) organization, supports the mission, vision and values of Wellmont through the use of community involvement and philanthropic support. As the fundraising arm of Wellmont, Wellmont Foundation serves all of its hospitals and service lines throughout the region.

Mountain States Health Alliance Hospitals All Mountain States wholly owned hospitals operate under the tax identification number of the Mountain States Health Alliance Corporation. The wholly-owned Mountain States acute care hospitals are described below.	
Johnson City Medical Center (JCMC) (Johnson City, TN)	JCMC is a 445- bed regional tertiary referral center which also serves as a teaching hospital affiliated with East Tennessee State University. Founded in 1911, JCMC has transformed to provide a comprehensive array of inpatient and outpatient services, including advanced services and trauma services. Also located at JCMC are 34 skilled nursing beds, separately licensed as Franklin Transitional Care.
Niswonger Children's Hospital (Johnson City, TN)	Niswonger Children's Hospital is the region's only children's hospital. The 69-bed facility is staffed by pediatric experts to serve more than 200,000 children in a four-state, 29-county region. Niswonger provides a comprehensive array of inpatient and outpatient services for children. Niswonger houses one of only seven St. Jude Affiliate Clinics across the country.
Woodridge Psychiatric Hospital (Johnson City, TN)	Woodridge Psychiatric Hospital is an 84-bed inpatient provider of mental health and chemical dependency services for adults, adolescents, and children ages six and older. Woodridge is a psychiatrist-led facility that includes a team of mental health therapists, discharge planners, expressive therapists, and psychiatric nurses to assist the patient with finding the most beneficial level of treatment.
Indian Path Medical Center (Kingsport, TN)	Indian Path Medical Center (IPMC) is a 239-bed community hospital with roots dating back 40 years. Indian Path provides a full array of services, including emergency services and a variety of inpatient and outpatient services.
Sycamore Shoals Hospital (Elizabethton, TN)	Sycamore Shoals Hospital is a 121-bed acute care facility serving the residents of Carter and Johnson Counties. Sycamore Shoals offers a full array of services, including emergency services and a variety of inpatient and outpatient services. In addition, wellness services are provided through the Franklin Health and Fitness Center, located on the campus of Sycamore Shoals.
Franklin Woods Community Hospital (Johnson City, TN)	Franklin Woods Community Hospital is an 80-bed, LEED-certified* "green" facility. Opened in 2010, Franklin Woods provides a full array of services, including emergency medicine and a variety of inpatient and outpatient services. *Leadership in Energy and Environmental Design
Unicoi County Memorial Hospital (Erwin, TN)	Unicoi County Memorial Hospital, is a 48-bed acute care facility with an adjacent 46-bed skilled nursing facility. The hospital was founded in 1953 in Erwin, TN, and serves the residents of Unicoi County and the surrounding areas with a full array of services, including emergency services and a variety of inpatient and outpatient services.
Russell County Medical Center (Lebanon, VA)	Russell County Medical Center is a 78-bed, acute care and behavioral health hospital. The hospital serves the residents of Russell County, VA, and provides behavioral health services, emergency services, and a variety of inpatient and outpatient services.

Johnson County Community Hospital (Mountain City, TN)	Johnson County Community Hospital is a two-bed critical access hospital opened in 1998 by Mountain States Health Alliance, offering emergency services and a variety of inpatient and outpatient services to the residents of Johnson County.

Mountain States' Joint Venture Facilities Mountain States' integrated healthcare delivery system also includes joint ventured facilities. The following summaries describe the joint venture entities.	
James H. and Cecile Quillen Rehabilitation Hospital (Johnson City, TN)	Quillen Rehabilitation Hospital houses 26 inpatient rehabilitation beds. The hospital is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and also provides a CARF-accredited stroke program. QRH offers pediatric and adolescent therapy for a wide range of diagnoses, such as stroke, brain injury, amputation, spinal cord injury, orthopedic injury, rheumatologic impairments, neurological and neuromuscular problems and major multiple trauma. The Mountain States partnership with HealthSouth consists of a stand-alone rehabilitation hospital joint venture of at least 36 rehab beds, with Mountain States maintaining a minority interest, and 50/50 board presence. The partnership with Signature HealthCARE will result in a skilled nursing facility with 47 beds and an assisted living facility with 60 beds.
Smyth County Community Hospital (Marion, VA)	Smyth County Community Hospital is a 44-bed, acute care facility located in Marion, VA. Smyth County's services also include a 109-bed skilled nursing care facility, branded as Francis Marion Manor Health & Rehabilitation. The hospital has served the residents of Smyth County, VA, for more than 45 years through a full array of services, including emergency services and a variety of inpatient and outpatient services. Smyth County Community Hospital also owns 100% of Southwest Community Health Services, Inc., described below.
Southwest Community Health Services, Inc.	Southwest Community Health Services is a for-profit entity, owned by Smyth County Community Hospital, which operates a pharmacy and provides other health services to the residents of Smyth County, VA.
Norton Community Hospital (Norton, VA)	Norton Community Hospital has served Southwest Virginia and Southeastern Kentucky since 1949. The 129-bed, acute care facility provides a full array of services, including emergency services and a variety of inpatient and outpatient services. Norton Community was the first American Osteopathic Association-accredited teaching facility in the commonwealth of Virginia and hosts residents in internal medicine.
Norton Community Physician Services, LLC	Norton Community Physician Services is a for-profit entity consisting of physician practices and pharmacy. NCPS employs 16 physicians and 4 mid-levels to serve the residents of Wise County and surrounding area.
Dickenson Community Hospital (Clintwood, VA)	Dickenson Community Hospital is one of two critical access hospitals operated by Mountain States Health Alliance. The hospital is licensed for 25 beds and provides emergency services and a variety of inpatient and outpatient services to the residents of Dickenson County.

Community Home Care, Inc.	Community Home Care is a home health agency located in Norton City, VA, that provides comprehensive quality care to patients within the comfort of their home.
Johnston Memorial Hospital (Abingdon, VA)	Johnston Memorial Hospital (JMH) is a 116-bed community hospital which was relocated to a new, state of the art facility in 2011. At that time, JMH was recognized as the first Gold Leadership in Energy and Environmental Design (LEED)-certified hospital in Southwest Virginia providing a full array of services, including emergency services and a variety of inpatient and outpatient services.
Abingdon Physician Partners	Abingdon Physician Partners is a physician practice owned and managed by Johnston Memorial Hospital consisting of 16 physicians and 5 mid-levels. JMH is 100% owner of Abingdon Physician Partners.
JMH Emergency Physicians, LLC	Johnston Memorial Hospital Emergency Physicians are fully employed ER physicians providing 24-hour emergency department coverage. JMH is 100% owner of JMH Emergency Physicians, LLC.

Other Mountain States' Entities Mountain States' integrated healthcare delivery system also includes other entities providing a variety of patient care and population health services. The following summaries describe other Mountain States corporate entities and their affiliates/subsidiaries.	
Integrated Solutions Health Network	Mountain States offers advanced population health management services through its subsidiary, Integrated Solutions Health Network (ISHN). ISHN is the corporate parent of AnewCare Collaborative and CrestPoint Health. AnewCare Collaborative is Mountain States' Accountable Care Organization, which operates a 14,000-member Medicare Shared Savings Program. CrestPoint Health operates TPA services for Mountain States team members and a Medicare Advantage Product with more than 5,000 covered lives at the end of 2015.
Mountain States Health Alliance Auxiliary, Inc.	The Mountain States Auxiliary was established in 1979 to provide financial support for various projects, particularly ones involving extra benefits for Mountain States team members, patients, and guests. The Auxiliary operates the Gift Shops and conducts sales of such items as uniforms, jewelry and books.
Blue Ridge Medical Management Corporation	Blue Ridge Medical Management Corporation (BRMMC) is a wholly owned, for-profit subsidiary of Mountain States Health Alliance. BRMMC owns and manages physician practices throughout the service area through its integrated physician organization, Mountain States Medical Group. Mountain States Medical Group includes more than 250 providers in over 90 locations representing 25 specialties, including eight urgent care sites. In addition to Mountain States Medical Group, other business units of BRMMC include Mountain States Properties, a real estate division which owns and manages almost one million square feet of medical office space; HealthPro Staffing, a staffing agency formed to provide staffing solutions to the Mountain States Health Alliance facilities and other healthcare organizations in the region; Medi-Serve Medical Equipment Company, a durable medical equipment and respiratory services company with three locations in Northeast Tennessee and Southwest Virginia; Mountain States Pharmacy, a retail pharmacy with five locations in Northeast Tennessee and Southwest Virginia; The Wellness Center, a health and fitness center; and ownership and investment in a number of joint ventures such as ambulatory surgery centers and urgent care facilities.

Mountain States Foundation	Mountain States Foundation is a not-for-profit entity providing philanthropic support to Mountain States Health Alliance through the coordination of fundraising and development activities. The Mountain States Foundation assisted with fundraising for the Niswonger Children's Hospital, Johnson City Medical Center radiation oncology expansion, and various fundraising opportunities at local facilities throughout the system.

Exhibit 10.2

Record of Community Stakeholder and Consumer Views

of the Proposed Cooperative Agreement

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Attachment B: Newsletters
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Attachment F: Southwest Virginia 2020 Summit Summary Report
Attachment G: Community Letters of Support

1. INTRODUCTION: SHARED COMMITMENT TO COMMUNITY & STAKEHOLDER ENGAGEMENT

Wellmont Health System and Mountain States Health Alliance (collectively, the "Parties") made a significant announcement on April 2, 2015 – the two organizations agreed to explore the creation of a new, integrated and locally governed health system designed to be among the best in the nation and address the serious health issues facing Northeast Tennessee and Southwest Virginia.

In order to consummate the merger, the Parties must obtain approval from the State of Tennessee and the Commonwealth of Virginia. If approved, the Parties will enter into Cooperative Agreements with each State, which will outline the ongoing obligations of the Parties to the region and the terms of the ongoing supervision of the Cooperative Agreement by each State.

The Parties recognize the once-in-a-lifetime opportunity and know the success of the merger depends on the involvement of the stakeholders throughout the region, including residents, employees, patients, payers, and business and community members and leaders. In order to foster involvement, the Parties undertook extensive efforts to educate, update, and engage all stakeholders.

The public information and education efforts began with the launch of a new website, www.BecomingBetterTogether.org, designed to provide an overview of the Parties' vision for the future, process to join together, answers to frequently asked questions, the latest news and updates, opportunities to submit questions and comments, and other helpful information. The Parties also provided updates to the community through press releases, Better Together newsletter updates to employees and more than 600 newsletter subscribers, internal updates and town hall meetings, presentations to community and civic group organizations, and other outreach initiatives.

Leaders from both systems have also talked with community members throughout the region, in auditoriums, coffee shops and restaurants, local businesses, higher education centers, and other venues, to seek input on the new health system the Parties envision for the region. Through the Community Health Work Group initiative in partnership with East Tennessee State University (ETSU), more than 150 community members to date have participated in work groups focused on discussing four key areas for health improvement in the region: Mental Health & Addiction, Healthy Children & Families, Research & Academics, and Population Health & Healthy Communities. Additionally, in cooperation with the College of Public Health at ETSU and in connection with the Parties' goal to improve health care services through the new health system, the Parties have jointly sponsored and funded the region's most substantial community health improvement assessment effort to date. The Parties also conducted 10 roundtable meetings where more than 175 community members gathered to discuss important local health issues.

All of the feedback collected since the merger was announced in Spring 2015 was used by the Parties to create the Pre-Submission Report, which invited the community to review and comment on its contents. This Exhibit provides a detailed outline of these many efforts to provide public information and education about the propsed Cooperative Agreement and the stakeholder feedback collected from across the region. The Parties are strongly committed to transparency in the Cooperative Agreement process and and seek to fully engage all stakeholders, whose input will serve as the foundation for the new health system.

2. OFFICIAL BECOMING BETTER TOGETHER PRESS RELEASES

The Parties distributed seven press releases to local and national media to provide the latest information about the proposed merger and the process the Parties are following to obtain a Certificate of Public Advantage (COPA) in Tennessee and a Letter Authorizing Cooperative Agreeement in Virginia. The press releases are included in this Exhibit and are archived on the Stay Informed page on the Better Together website.

Table 1. OFFICIAL BETTER TOGETHER ANNOUNCEMENTS	
4/2/2015	Wellmont Health System, Mountain States Health Alliance Announce Plans to Pursue an Integrated Health System
4/7/2015	Wellmont Health System, Mountain States Health Alliance Name Members of Integration Council
5/6/2015	Wellmont Health System, Mountain States Health Alliance Name Members of Joint Board Task Force
6/10/2015	Wellmont Health System, Mountain States Health Alliance to Seek Input on Key Health Issues, Call for Public Participation
8/5/2015	Wellmont, Mountain States Announce Chairs, Meeting Dates for Community Health Work Groups
9/16/2015	Wellmont, Mountain States File Letters of Intent to Begin Regulatory Approval Process in Tennessee and Virginia
1/7/2016	Wellmont, Mountain States Share Public Report Outlining Future Plans to Improve Health in Region

See ATTACHMENT A: Press Releases

3. BETTER TOGETHER NEWSLETTERS

As part of the Parties' commitment to keep community members and employees and physicians of both systems informed, the Parties developed an electronic Better Together Newsletter to highlight important information, including updates, key milestones of the process, and answers to frequently asked questions. Community members can sign up for the newsletter by visiting the Better Together website and were also invited to sign up at various community and internal events. Newsletters were also distributed to employees and physicians at both health systems. There are currently more than 600 people subscribed to receive Better Together Newsletters. **Attachment B** includes copies of all Better Together Newsletters.

Table 2. BETTER TOGETHER NEWSLETTERS	
Date	**Headline**
4/16/2015	Answering Your Questions, Our Vision, Questions of the Week
5/6/2015	Thank You, News and Updates, In the News, Questions of the Week
6/2/2016	News & Updates, Community Support, Questions of the Week
6/10/2016	Wellmont, Mountain States to Seek Input on Key Health Issues
8/5/2015	Wellmont, Mountain States Announce Community Health Work Groups Meeting Dates and Chairs
8/28/2015	Wellmont and Mountain States continue to make progress on exploring the creation of a new, integrated and locally governed health system, News & Updates
9/16/2015	Wellmont, Mountain States Take Important Next Steps in Proposed Merger Process, Community Support Continues
1/7/2016	Wellmont, Mountain States Share Exciting Commitments to Improve Region's Health

See ATTACHMENT B: Newsletters

4. EMPLOYEE AND PHYSICIAN INTERNAL ENGAGEMENT EFFORTS

In addition to the Better Together Newsletters, the Parties have provided ongoing updates to employees and physicians through various internal communications channels, such as employee and physician meetings, town hall updates and internal memos. **Attachment C** includes copies of the presentation materials distributed to employees and used at the internal town hall meetings and presentations.

A. INTERNAL TOWN HALL MEETINGS PRIOR TO RELEASE OF PRE-SUBMISSION REPORT

The following is a list of intentional outreach efforts by Wellmont Health System:

Table 3. WELLMONT HEALTH SYSTEM EMPLOYEE TOWN HALL MEETINGS PRIOR TO PRE-SUBMISSION REPORT	
Hawkins County Memorial Hospital April 1 at 8 a.m., 11 a.m. and 7 p.m. June 25 at 7 a.m. and noon June 26 at 7 a.m. August 27 at 3 p.m. August 28 at 7 a.m. and noon September 1 at 6 p.m. September 3 at 7 a.m. and 10 a.m. September 4 at 10 a.m.	**Wellmont Corporate Offices** April 1 at 9 a.m., 10 a.m. and 11 a.m. April 2 at 10 a.m., 2 p.m. and 4 p.m. June 23 at 10 a.m. and 11 a.m. June 24 at 9 a.m., 10 a.m. and 2 p.m. September 1 at 9 a.m., 10 a.m., 11 a.m. September 2 at 3 p.m. September 4 at 3 p.m.
Mountain View Regional Medical Center April 1 at 5 p.m. and 7 p.m. April 2 at 7 a.m. and 11 a.m. April 3 at 11 a.m. June 30 August 27	**Lonesome Pine Hospital** April 1 at 11 a.m. and 2 p.m. April 2 at 3 p.m. and 5 p.m. April 3 at 7 a.m. June 30 July 1 August 25
Holston Valley Medical Center April 1 at 2 p.m., 6 p.m. and 10 p.m. April 2 at 7 a.m. and 9 a.m. April 3 at 10 a.m. and 2 p.m. April 4 at 7 a.m. and noon June 27 at 7 a.m. and 10 a.m. June 29 at 10:30 a.m. June 30 at 7 a.m., 2:30 p.m., 7 p.m. July 1 at noon, 3 p.m. Aug. 26 at 7 a.m. and 10 a.m. Aug. 27 at 2 p.m. and 7 p.m. Aug. 29 at 10 a.m. Aug. 31 at noon	**Bristol Regional Medical Center** April 1 at 10:30 a.m. and 4 p.m. April 2 at noon and 4 p.m. April 3 at 10 a.m. and 2 p.m. June 29 at 7 a.m. and 9 a.m. June 30 at 3 p.m. July 1 at noon July 1 at 7 p.m. July 2 at 2 p.m. August 24 at 3 p.m. August 26 at 2 p.m. August 28 at 10 a.m. *The following quarterly nursing staff meetings also included Town Hall presentations:* August 25 at 7:45 a.m. and 8:30 p.m. August 27 at 9 a.m. and 7:45 p.m.
Hancock County Hospital April 1 at 2 p.m. June 24 at 1:30 p.m. August 26 at 1:30 p.m.	

September 1 at 1:30 p.m.	

In addition to internal town hall meetings, Wellmont has provided ongoing updates to physicians at regularly scheduled meetings:

- **Holston Valley Medical Center & Bristol Regional Medical Center:** Updates occur at every monthly Medical Executive Committee meeting, monthly Physician Clinical Council meeting, quarterly medical staff meeting and monthly hospital board meeting.
- **Hawkins County Memorial Hospital**: Updates occur at medical/staff quality meetings, which occur every other month and the Medical Executive Committee, which occurs every other month.
- **Hancock County Hospital**: Updates occur at the Medical Executive Committee/Quality meeting, which occurs every other month.
- **Lonesome Pine Hospital & Mountain View Regional Medical Center**: Updates occur at the quarterly medical staff meeting and frequently at the monthly Medical Executive Committee meeting.

The following is a list of intentional outreach efforts by Mountain States Health Alliance:

Table 4. MOUNTAIN STATES HEALTH ALLIANCE EMPLOYEE TOWN HALL MEETINGS PRIOR TO PRE-SUBMISSION REPORT	
Johnston Memorial Hospital April 1 at 4:30 p.m., 6:30 p.m. and 7:30 p.m. April 2 at 7:30 a.m., 10:30 a.m. and 2:30 p.m.	**Russell County Medical Center** April 1 at 4:30 p.m., 6:30 p.m. and 7:30 p.m. April 2 at 10:30 a.m. and 2:30 p.m.
Woodridge Psychiatric Hospital April 2 at 7:15 p.m. April 3 at 7:15 a.m. May 20 at 7:15 p.m. May 22 at 11:30 a.m. May 29 at 7:15 a.m. May 29 at 11:30 a.m. June 3 at 7:15 p.m. July 8 at 7:15 a.m. July 9 at 11 a.m.	**Johnson City Medical Center / Niswonger Children's Hospital** April 1 at 10:00 a.m. April 1 at 7:15 p.m. April 2 at 7:15 a.m. April 2 at 5:30 p.m. April 3 at 7:15 a.m. April 3 at 11:00 a.m. May 20 at 7:15 p.m. May 22 at 11:30 a.m. May 29 at 7:15 a.m. July 14 at 7:30 a.m. July 16 at 7:30 p.m. July 29 at 11:30 a.m. November 3 at 7:15 p.m. November 6 at 12:00 p.m. November 9 at 7:15 a.m.
Norton Community Hospital April 2 at 7:30 a.m., 10 a.m., 2 p.m. and 8 p.m. April 3 at 11 a.m., 1 p.m. and 3 p.m. July 21 at 7:30 a.m., 1:30 p.m. and 8 p.m. July 22 at 10:30 a.m. July 24 August 25 at 7:30 a.m. & 10 a.m. August 26 at 7:30 a.m., 9:30 a.m., 8 p.m. August 27 at 3:00 p.m.	**Indian Path Medical Center** April 1 at 4:30 p.m. and 8 p.m. April 2 at 6 a.m., 8 a.m., 10 a.m., noon, 2 p.m., 6 p.m. & 8 p.m. April 3 at 11:30 a.m. and 12:30 p.m. Sept. 15 at 4:30 p.m. Sept. 16 at 7:30 a.m. Dec. 15 at 4:30 p.m. Dec. 16 at 7:30 a.m.
Franklin Woods Community Hospital April 1 at 6:30 p.m. April 2 at 6 a.m., 6:15 a.m. and 11 a.m. July 7 at 11 a.m.	**Smyth County Community Hospital / Francis Marion Manor** April 1 at 7:30 p.m. April 2 at 8:00 a.m. April 2 at 9:30 a.m.

Table 4. MOUNTAIN STATES HEALTH ALLIANCE EMPLOYEE TOWN HALL MEETINGS PRIOR TO PRE-SUBMISSION REPORT	
July 10 at 7:15 a.m. July 15 at 7:15 p.m.	April 2 at 10:30 p.m. April 2 at 2:30 p.m.
Sycamore Shoals Hospital April 1 at 4:30 p.m. and 8 p.m. April 2 at 8 a.m. and 9 a.m. June 19 at noon Aug. 27 at noon Oct. 16 at noon Dec. 11 at noon	**Unicoi County Memorial Hospital** April 1 at 1:00 p.m. April 2 at 7:30 a.m. April 2 at 4:30 p.m.
Johnson County Community Hospital April 1 at 7 p.m. April 2 at noon	**Mountain States Corporate Offices** April 3 at 9 a.m. April 17 at 2 p.m.
Smyth County Community Hospital April 1 at 4:30 p.m. and 6:30 p.m.	**Home Health** April 2 at 8:30 a.m. (Johnson City) April 3 at 8:30 a.m. (Abingdon)
Dickenson Community Hospital April 2 at 3:00 p.m. August 6 at 10 a.m. August 28 at 7:15 p.m.	

In addition to internal town hall meetings, Mountain States has routinely offered merger updates at monthly and quarterly medical staff meetings at all facilities. Routine updates have also been provided as part of monthly department director and manager meetings.

See ATTACHMENT C:
Internal Town Hall Presentations

B. INTERNAL TOWN HALL MEETINGS AFTER RELEASE OF PRE-SUBMISSION REPORT

Following the release of the Pre-Submission Report on January 7, 2016, the Parties held more than 80 Town Hall meetings to provide employees and physicians an opportunity to learn more about the proposed commitments and ask questions related to the content of the Report or the merger. These meetings consisted of a prepared presentation that highlighted important information contained within the Pre-Submission Report and an open question and answer period. The following is a list of the meetings conducted by both Wellmont and Mountain States, including location and dates of meetings. A summary of questions and comments received at these meetings is included in Section C below. Copies of the materials used in the town hall meeting presentations are included in **Attachment C**.

Tables 5 & 6 include the schedule for all internal Town Hall meetings scheduled by the Parties through January 31, 2016.

Table 5. WELLMONT HEALTH SYSTEM EMPLOYEE TOWN HALL MEETINGS FOLLOWING RELEASE OF PRE-SUBMISSION REPORT

Hawkins County Memorial Hospital January 12, 2016 – 2:00 pm January 12, 2016 – 3:00 pm January 13, 2016 – 7:00 pm January 15, 2016 – 3:00 pm	**Wellmont Corporate Offices** January 13, 2016 – 10:00 am January 14, 2016 – 1:00 pm January 14, 2016 – 2:00 pm January 15, 2016 – 2:00 pm
Mountain View Regional Medical Center January 12, 2016 – 7:00 am January 13, 2016 – 2:00 pm	**Lonesome Pine Hospital** January 12, 2016 – 2:00 pm January 13, 2016 – 7:00 am
Holston Valley Medical Center January 14, 2016 – 10:30 am January 15, 2016 – 2:00 pm January 16, 2016 – 10:00 am January 19, 2016 – 7:00 pm January 20, 2016 – 7:00 am January 26, 2016 – 12:00 pm	**Bristol Regional Medical Center** January 15, 2016 – 7:30 am January 18, 2016 – 9:00 am January 19, 2016 – 11:00 am January 19, 2016 – 4:00 pm January 21, 2016 – 7:30 am
Hancock County Hospital January 13, 2016 – 2:00 pm	

Table 6. MOUNTAIN STATES HEALTH ALLIANCE EMPLOYEE TOWN HALL MEETINGS FOLLOWING RELEASE OF PRE-SUBMISSION REPORT	
Johnston Memorial Hospital January 18, 2016 – 7:30 am January 18, 2016 – 9:00 am January 20, 2016 – ED Committee January 21, 2016 – 12:30 pm January 21, 2016 – 5:00 pm January 21, 2016 – 7:30 pm January 25, 2016 – 9:00 am January 28, 2016 – 6:00 pm January 28, 2016 – 7:30 pm	**Mountain States Corporate Offices** January 18, 2016 – 5:15 pm January 15, 2016 – 5:15 pm January 19, 2016 – 9:00 am January 7, 2016 – 10:00 am January 22, 2016 – 2:00 pm January 13, 2016 – 11 am January 22, 2016 – 3:30 pm January 22, 2016 – 2:00 pm
Blue Ridge Medical Management Corp. January 19, 2016 – 5:15 pm January 20, 2016 – 8:00 am January 20, 2016 – 5:15 pm January 22, 2016 – 7:30 am	**Russell County Medical Center** January 26, 2016 –7:00 am January 26, 2016 – 6:00 pm January 28, 2016 – 11:00 am January 28, 2016 – 2:00 pm
Johnson City Medical Center / Niswonger Children's Hospital January 19, 2016 – 7:00 pm January 20, 2016 – 11:00 am January 20, 2016 – 2:00 pm January 21, 2016 – 7:00 am	**Indian Path Medical Center** January 18, 2016 – 4:00 pm January 19, 2016 – 9:00 am January 20, 2016 – 7:00 am January 21, 2016 – 1:00 pm
Johnson County Community Hospital January 19, 2016 – 4:30 pm January 22, 2016 – 12:00 pm	**Unicoi County Memorial Hospital** January 19, 2016 – 1:00 pm January 19, 2016 – 6:30 pm
Home Health January 19, 2016 – 7:30 am January 20, 2016 – 8:30 am January 26, 2016 – 8:30 am	**Norton Community Hospital** January 19, 2016 – 1:30 pm January 19, 2016 – 8:30 pm January 20, 2016 – 7:30 am January 21, 2016 – 10:00 am January 21, 2016 – 1:30 pm
Franklin Woods Community Hospital January 14, 2016 – 7:15 am January 19, 2016 – 11:00 am January 21, 2016 – 9:00 pm	**Smyth County Community Hospital** January 19, 2016 – 6:30 pm January 20, 2016 –3:30 pm January 21, 2016 – 3:00 pm January 21, 2016 – 3:30 pm
Sycamore Shoals Hospital January 18, 2016 – 10:00 am January 18, 2016 – 6:00 pm January 21, 2016 – 12:30 pm	**Dickenson Community Hospital** January 18, 2016 – 1:30 pm
Woodridge Psychiatric Hospital January 19, 2016 – 7:15 pm January 21, 2016 – 4:00 pm	

C. INTERNAL TOWN HALL MEETING SUMMARIES

The following are detailed summary reports of the comments and questions received at each internal town hall meeting conducted by Wellmont and Mountain States.

1. WELLMONT HEALTH SYSTEM TOWN HALL MEETING SUMMARIES

Hawkins County Memorial Hospital	**Wellmont Health System**
January 12, 2016 – 2:00 pm January 12, 2016 – 3:00 pm January 13, 2016 – 7:00 pm January 15, 2016 – 3:00 pm	**LOCATION:** Rogersville, TN
QUESTIONS/COMMENTS: • Will there be elimination of smaller facilities after the five-year period outlined in the pre-submission report? • Will employees keep their accumulated PTO and move it to the new system or will they be paid for it and have to start over? • What will our employee health insurance plan look like? • What are the telemedicine opportunities we might pursue? • If the merger is approved and jobs become open, will staff members have an opportunity to move around? • Will clinical educators have a role as we pursue the community health improvement initiatives • What will happen with our retirement plans? • Will the health insurance plan remain the same or change? • Will we continue to have a debit card with the plan? • What is the approximate date when the proposed merger will be final? • What will happen to the job of Quest lab employees? • A comment was made suggesting insurance benefits would be better or at least offset as far as cost increases.	

Hancock County Hospital	**Wellmont Health System**
January 13, 2016 – 2:00 pm	**LOCATION:** Sneedville, TN
QUESTIONS/COMMENTS: • Will the CAPS program stay the same? Could the rate of pay go down?	

Wellmont Corporate Offices	Wellmont Health System
January 13, 2016 – 10:00 am January 14, 2016 – 1:00 pm January 14, 2016 – 2:00 pm January 15, 2016 – 2:00 pm	**LOCATION:** Kingsport, TN

QUESTIONS/COMMENTS:

- How can we square efficiencies with investments and job growth?
- What about the non-tertiary hospitals?
- Could the community hospital division hospitals close before the merger?
- What is the time frame for the unwind plan?
- How will the pediatrics plan affect the East Tennessee Children's Hospital partnership?
- Are we going to see more information unrolling?
- Why aren't there plans for a Virginia tertiary hospital?
- What's the timeline for post-merger decisions, such as IT systems?
- Going between Star and Epic, some things are being deleted in transfer. What are we going to do about it? Physicians, billing, medical records all need the information and we want images to be matched with reports.
- When can we talk with MSHA?
- Insurance keeps going up – it is a monopoly. What happens with that? What about the patient?
- Do you look for Anthem to come on board?
- When do you (Todd) project closing?
- The website was supposed to keep us better informed. It's not updated. It hasn't been in months. We have not been informed about anything. The newspaper tells us stuff weeks before we are told. Why couldn't you have told us you were working on the pre submission report?
- You said a community free of drug problems. Are you talking about the community itself or physician community?
- We did 11 programs on opioid abuse for physicians what are we doing for the community? What programs will they have?
- What if the state says no to the merger?
- Anthem is in Virginia, will that make Virginia approval an issue?
- Are there any other insurance companies causing problems?
- To keep us informed of what is being met about, can we have the ELT meeting minutes?
- You keep saying "if we go to EPIC." We spent that much money; we shouldn't get rid of it.
- When Todd Dougan said "you may be asking yourself, where will the $450 million be coming from," the audience responded quickly with "no raises"
- If an outside agency comes in, they let go of local people and then money goes back to the new company. I agree with our path because local will take care of local.
- We need to recruit for psychiatry.
- Doctors that are prescribing drugs need to check on their patients and see if they can come off those drugs. We should be looking for natural solutions.
- Where is the money for the investments coming from?
- Is the "black box" information a recommendation or a requirement? Will it be in the COPA?
- When will we have details?

- What if Virginia requests an additional Southwest Virginia facility?
- Have there been discussions about a new brand/name?
- Will ETSU be eligible for new funding and grants?
- Can Holston Valley accommodate Indian Path's case load?
- Where are the "black box" people and consultants located? Who chose them?
- Who manages the state oversight? Is there a board of licensure? How is this reported?
- Do we have a baseline of success for community health?
- When does the five-year period for facilities begin?
- How are we going to pay for the $450 million?
- Will the initial investment put us in debt?
- What happens to the facilities after five years?
- What's in this for the states?
- Will we be recruiting jobs/positions nationally? Will we be nationally competitive?
- Will there be an open dialogue throughout the COPA approval process?
- What if one state agrees but one doesn't?
- What are the chances a federal agency will step in and block this?
- What happened to the $5 billion amount earlier consultants said we needed before the MSHA announcement?
- Can the state extend the approval period?
- Are there similar mergers we can look to?
- What happens if we don't meet the commitments?
- Can someone report us if we don't meet a commitment?
- Will there be conflicts – like benefits – similar to the BRMC/HVMC merger?
- When can we expect to see opportunities and growth – specifically career development opportunities?

Bristol Regional Medical Center	**Wellmont Health System**
January 15, 2016 – 7:30 am January 18, 2016 – 9:00 am January 19, 2016 – 11:00 am January 19, 2016 – 4:00 pm January 21, 2016 – 7:30 am	**LOCATION:** Bristol, TN

QUESTIONS/COMMENTS:

- Patients have confessed to me that they are scared about the potential merger. They make it sound like Mountain States isn't as good of a health care system and that their culture isn't as friendly. They simply have a bad perception of them, rather it be from actual experiences or word of mouth. Most of my patients feel Bristol Regional is known for treating patients more like family, especially compared to non-Wellmont facilities.
- How do benefits work and what does that mean for me?
- Are there vast differences in our benefit, PTO and insurance plans? I've heard MSHA pay more in premium cost and can't hold as much PTO as we do.
- Who is going to have more control going forward? Are we going to have to adapt to how MSHA does things?
- What can we expect for our insurance, premiums and benefits - are we still going to be a high deductible plan?

- I am excited about spending money on research. However, is the research money we spend going to be assessed and valued? There are weird research campaigns going on in our area, like the study of cow flatulence on respiratory systems. How are we going to ensure these research projects we invest in are meaningful?
- What are we thinking along the lines of depleting substance abuse in our area? Do we have plans yet and will we get an opportunity to participate in these meetings and be a part of these think tanks?
- These commitments over the next 10 years sound expensive, how are we paying for it all - consolidations, loss of jobs, closing facilities?
- As far as community hospitals go, I am assuming they will fall under one umbrella and the new health care system, right? What about the existing contracts we have, like our skilled nursing facilities and contracted providers? What all are we keeping?
- Let's assume this merger actually happens and is approved, what's the timeframe until we'd be a new health care system finally?
- Will the community investments of $450 million start on day one or later after we're a functioning health care system?
- Is there a chance this won't be approved?

Holston Valley Medical Center	**Wellmont Health System**
January 14, 2016 – 10:30 am January 15, 2016 – 2:00 pm January 16, 2016 – 10:00 am January 19, 2016 – 7:00 pm January 20, 2016 – 7:00 am January 26, 2016 – 12:00 pm	**LOCATION:** Kingsport, TN

QUESTIONS/COMMENTS:

- What part does the Federal Government play in this process?
- What if one state approves and the other does not?
- If there is no competition then there really isn't a need for improvements, correct?
- Can we afford to invest $45 million a year after consolidating services and cutting health care costs without going into more debt?
- Are we suspending capital purchases/improvements in preparation for the merger?
- I've heard some state lawmakers oppose. Do we know who they are?
- Will we still have two Level One Trauma Centers? If not, would it be centrally located?
- When services are consolidated, have you projected the loss of jobs?
- An employee's husband stated he felt there was no concern for Wellmont if the merger didn't take place.
- What would the transition phase look like if it is determined one of our current facilities will be utilized for something different?
- Do both states have the same time period of which they would be expected to oversee/supervise the operations of the new health system?
- Will there be details in the COPA outlining how the states will provide oversight?
- Are/will the two states be working together or independently?
- Will the COPA satisfy the FTC?

Mountain View Regional Medical Center	Wellmont Health System
January 12, 2016 – 7:00 am January 13, 2016 – 2:00 pm	**LOCATION:** Norton, VA

QUESTIONS/COMMENTS:

- Who, at a state level, will be receiving the report?
- Do you see a "mass exodus" with regards to our physicians/clinical staff?
- Will insurance plans be decided before or after everything is done?
- If the states do not approve, then what?

Lonesome Pine Hospital	Wellmont Health System
January 12, 2016 – 2:00 pm January 13, 2016 – 7:00 am	**LOCATION:** Big Stone Gap, VA

QUESTIONS/COMMENTS:

- If State of Tennessee and State of Virginia do not approve everything, do we still move forward?
- If you read in the pre-submission report that the hospitals will run for 5 years does that mean we run as is or will there be change of some sort?
- Do things change after 5 years?
- What about jobs?
- If a person is marked as a no hire at one facility and the other health system hires that person and then that person is, yet again let go, they wouldn't have anywhere to go*- would they?
- In respiratory, there is a pool of workers so will that pool be eligible to move to another facility?
- Will the new company actually take info from the inside (clinical areas and areas as a whole?
- Is Lee County being considered at all?

2. MOUNTAIN STATES HEALTH ALLIANCE TOWN HALL MEETING SUMMARIES

Blue Ridge Medical Management Corp.	Mountain States Health Alliance
January 19, 2016 – 5:15 pm January 20, 2016 – 8:00 am January 20, 2016 – 5:15 pm January 22, 2016 – 7:30 am	**LOCATIONS:** Johnson City, TN Mountain City, TN Kingsport, TN Abingdon, VA

QUESTIONS/COMMENTS:

- Will we adopt Wellmont's EHR or will they adopt ours?
- Are we going to change the dress code?
    - Will we still have to wear this blue?
- Will family practice sites have to reapply to be certified as a patient centered medical home (PCMH)?
- Has there been any discussion regarding GME positions that would be offered?
    - Added?
    - New residency programs?
- What has been the response from ETSU?

Mountain States Corporate Offices	Mountain States Health Alliance
January 18, 2016 – 5:15 pm January 15, 2016 – 5:15 pm January 19, 2016 – 9:00 am January 7, 2016 – 10:00 am January 22, 2016 – 2:00 pm January 13, 2016 – 3:00 pm January 22, 2016 – 3:30 pm	**LOCATION:** Johnson City, TN

QUESTIONS/COMMENTS:

- What is the cost of getting the State "COPA" agreements?
- How do the residents of Kingsport feel about this merger?
- How will for-profit be handled as is related to MSMG & Wellmont's Physician groups?
    - Will they remain for-profit?
- Will the new entity be not for profit?
- What happens if one state only approves?
- What EHR would we go with?
- If the merger doesn't happen, can Wellmont stand on its own?
- Will the two IS Departments be merged and has there been any discussion about how the new department will be organized?
- Will the newly formed company have a new name and new logo?
- Has there been any discussion on how to handle behavioral health across our region with respect to the new company? Will we continue with psych services?
- Has a budget been detailed out for how we will cover all expenses for IS systems? Will the "up to $150 million for IT Systems cover everything?"
- Has there been consideration regarding the new system partnering with the community and education systems to assist with college tuitions, increase job opportunities, etc. in order to

improve the standard of living, raise education levels and therefore improve community health?
- Does the merger ultimately have to be approved by the FTC?
- Are the TN and VA state offices communicating with each other about the merger?

Dickenson Community Hospital	Mountain States Health Alliance
January 18, 2016 – 1:30 pm	**LOCATION:** Clintwood, VA
QUESTIONS/COMMENTS: • No questions or comments received at Town Hall meeting.	

Franklin Woods Community Hospital	Mountain States Health Alliance
January 14, 2016 – 7:15 am January 19, 2016 – 11:00 am January 21, 2016 – 9:00 pm	**LOCATION:** Johnson City, TN
QUESTIONS/COMMENTS: • Public sentiment - is it changing from fears of becoming a monopoly? • Are we merging or are we buying them out? • Premier contracts currently used today? • Will Unicoi still be built? • Services such as services outsourced at Wellmont but MSHA are in house - how will that be handled? • IT platform for FBU - CPM currently used - will we be moving to Soarian?	

Home Health	Mountain States Health Alliance
January 19, 2016 – 7:30 am (Mediserve Gray) January 20, 2016 – 8:30 am (Johnson City) January 26, 2016 – 8:30 am (JMH Abingdon)	**LOCATION:** Johnson City, TN
QUESTIONS/COMMENTS: • No questions or comments received at Town Hall meetings.	

Indian Path Medical Center	Mountain States Health Alliance
January 18, 2016 – 4:00 pm January 19, 2016 – 9:00 am January 20, 2016 – 7:00 am January 21, 2016 – 1:00 pm	**LOCATION:** Kingsport, TN
QUESTIONS/COMMENTS: • What did the slide mean that said “Provide credit for accrued vacation and sick leave”. • When will we hear back from the COPA filing? • If Tennessee or Virginia make changes to the COPA would both states have to approve the changes to proceed? • Do you foresee any opposition? • Dr. Morris Seligman was on the line and commented on IT. He stated no decision has been made yet as to what system would be used but that with all will be on a common platform. He stated even if the merger is successful it will be at least 2018 before changes would be	

made.

- What will be the displacement rate of employees after the merger takes place? Is there a certain percentage that will lose their jobs?

Johnson County Community Hospital	Mountain States Health Alliance
January 19, 2016 – 4:30 pm January 22, 2016 – 12:00 pm	**LOCATION:** Mountain City, TN
QUESTIONS/COMMENTS: • Will there be a new name? • Will our insurance change? • If they did not allow us to retain our current PL and sick time, what would have happened? • Would it be possible for an urgent care to be at JCCH and if not, can our ED bills be lowered for TM's and families since we don't have access to an urgent care?	

Johnson City Medical Center / Niswonger Children's Hospital	Mountain States Health Alliance
January 19, 2016 – 7:00 pm January 20, 2016 – 11:00 am January 20, 2016 – 2:00 pm January 21, 2016 – 7:00 am	**LOCATION:** Johnson City, TN
QUESTIONS/COMMENTS: • When will the merger take place? • When the merger takes places, what about prices as there will be a monopoly? • What will happen with our benefits? As an additional question about benefits we are asked why our Wellness Center dues were more than other fitness centers, not making it affordable? • Has there been opposition to the merger? • I have elderly neighbors who are concerned about having a choice for healthcare, what can I share with them? • Are we looking at mental health programs for children?	

Johnston Memorial Hospital	Mountain States Health Alliance
January 18, 2016 – 7:30 am January 18, 2016 – 9:00 am January 20, 2016 – 7:30 am (ED Committee) January 21, 2016 – 12:30 pm January 21, 2016 – 5:00 pm January 21, 2016 – 7:30 pm January 25, 2016 – 9:00 am January 28, 2016 – 6:00 pm January 28, 2016 – 7:30 pm	**LOCATION:** Abingdon, VA
QUESTIONS/COMMENTS: • What is the time frame for IT conversion to a common IT platform?	

- There are two urgent cares in the area (Abingdon). What is the plan to deal with the duplication of services after the merger?
- How soon after the merger will we know the impact on our (ED physicians) jobs? Is there a plan to consolidate into one big ED group?
- Are certain organizations that know about the potential merger going to continue to fight it? Will it delay the process?
- How will we promote a drug free community?
- Will we standardize equipment like IV pumps?
- Will we be getting rid of MedHost?
- Will we all go to CrestPoint?
- What will we do about the 3rd grade education initiative?
- After states approve, does it go to the federal government?
- What is Anthem's primary issue with the merger?
- Will benefits change?
- Will benefits be equivalent to what we have now?

Norton Community Hospital	**Mountain States Health Alliance**
January 19, 2016 – 1:30 pm January 19, 2016 – 8:30 pm January 20, 2016 – 7:30 am January 21, 2016 – 10:00 am January 21, 2016 – 1:30 pm	**LOCATION:** Norton, VA
QUESTIONS/COMMENTS: • No questions or comments received at Town Hall Meetings	

Russell County Medical Center	**Mountain States Health Alliance**
January 26, 2016 –7:00 am January 26, 2016 – 6:00 pm January 28, 2016 – 11:00 am January 28, 2016 – 2:00 pm	**LOCATION:** Lebanon, VA
QUESTIONS/COMMENTS: • No questions or comments received at Town Hall meeting.	

Smyth County Community Hospital	**Mountain States Health Alliance**
January 19, 2016 – 6:30 pm(Pharmacy Task Force) January 20, 2016 –3:30 pm January 21, 2016 – 3:00 pm January 21, 2016 – 3:30 pm (Francis Marion Manor)	**LOCATION:** Marion, VA
QUESTIONS/COMMENTS: • Current timeline for finalization of the merger? • Concerns about no competition. One system versus two.	

- What you said about 'what could be accomplished if the merger happened that couldn't happen otherwise' explain what you meant.
- Assuming the merger happens, what monitoring will be in place to assure the quality has actually improved and goals achieved?

Sycamore Shoals Hospital	**Mountain States Health Alliance**
January 18, 2016 – 10:00 am January 18, 2016 – 6:00 pm January 21, 2016 – 12:30 pm	**LOCATION:** Elizabethton, TN

QUESTIONS/COMMENTS:

- What electronic health records system will we be using?
- How do we get around the anti-trust issue?
- What will be the new name and logo?
- What will happen with employees that currently work for both Mountain States and Wellmont in regards to service years and PTO, etc.?
- Which company has a more competitive pay scale?

Unicoi County Memorial Hospital	**Mountain States Health Alliance**
January 19, 2016 – 1:00 pm January 19, 2016 – 6:30 pm	**LOCATION:** Erwin, TN

QUESTIONS/COMMENTS:

- Whose benefits package will we adopt?
- How will this affect the construction of the new hospital in Unicoi Co?

Woodridge Psychiatric Hospital	**Mountain States Health Alliance**
January 19, 2016 – 7:15 pm January 21, 2016 – 4:00 pm	**LOCATION:** Johnson City, TN

QUESTIONS/COMMENTS:

- Both have urgent clinics - can we keep them open longer to ensure costs are controlled but ensure access?
- Do you have a model to follow from another company that has done this?
- How do you know what to keep/what not to keep?
- Excited about opportunities for mental health
- Target not only the addiction piece on drug abuse but also the chronic piece (residential gaps)
- Explore/pursue behavioral health center of excellence within next 6 months

5. COMMUNITY ENGAGEMENT EFFORTS

Since announcing the proposed merger in April 2015, the Parties have planned and/or participated in numerous community events and presentations, and a significant number of media interviews, with the goal of informing the community about the merger and soliciting and creating opportunities for the public to provide feedback. Below is a list of all external community engagement efforts of the Parties since the announcement of the proposed merger.

Presentation templates and handouts used at various community events and presentations are included as part of **Attachment D.**

A. COMMUNITY EVENTS AND PRESENTATIONS

Table 7. COMMUNITY EVENTS & PRESENTATIONS	
April 2, 2015	Proposed merger announcement public event
April 24, 2015	Kingsport Chamber breakfast
May 1, 2015	Bristol Tennessee/Virginia Chamber breakfast
May 6, 2015	Washington County Virginia Rotary
May 19, 2015	Johnson City Chamber Board
June 8, 2015	Kingsport Chamber Board
June 10, 2015	Southwest Virginia Health Authority
June 24, 2015	Bristol Tennessee/Virginia Chamber Board
July 7, 2015	Bristol Tennessee/Virginia Noon Rotary
July 23, 2015	Washington County Virginia Chamber Board
August 13, 2015	Elizabethton Community Round Table
August 20, 2015	Abingdon Community Round Table
August 20, 2015	Mental Health & Addiction Steering Meeting
August 24, 2015	Population Health Steering Committee
August 28, 2015	Kingsport Chamber Breakfast
September 3, 2015	Virginia Department of Health Public Hearing
September 8, 2015	Health Children Steering Committee
September 9, 2015	Mountain States Foundation Women's Luncheon
September 15, 2015	Marion Community Road Table
September 16, 2015	Johnson City Press Public Forum
September 17, 2015	Mental Health & Addiction Steering Committee
September 19, 2015	Sorensen Institute presentation
September 19, 2015	Lead Virginia
September 24, 2015	Research & Academics Steering Committee
September 24, 2015	Erwin Community Round Table
September 29, 2015	Lebanon, Virginia, Community Round Table
September 30, 2015	Johnson City Rotary
October 1, 2015	Kingsport Community Round Table
October 6, 2015	Duffield Community Round Table
October 13, 2015	Healthy Children & Families Steering Committee
October 15, 2015	Bristol Community Round Table
October 16, 2015	Regional Health Care Symposium
October 20, 2015	Wise Community Round Table

October 21, 2015	Mental Health & Addiction Steering Committee
October 22, 2015	Johnson City Community Round Table
October 22, 2015	United Way of Southwest Virginia Summit
October 26, 2015	Population Health & Healthy Communities Steering Committee
October 28, 2015	Research & Academics Steering Committee
November 10, 2015	Healthy Children & Families Steering Committee
November 12, 2015	Johnson City Rotary
November 16, 2015	All Work Groups Meeting – Accountable Care Communities
November 19, 2015	Mental Health & Addiction Steering Committee
December 2, 2015	Research & Academics Steering Committee
December 8, 2015	Healthy Children & Families Steering Committee
December 18, 2015	Mental Health & Addiction Steering Committee
December 18, 2015	All Work Groups Meeting – Impact of Opioids in Appalachia
January 5, 2016	Healthy Children & Families Steering Subcommittee
January 12, 2016	Healthy Children & Families Steering Committee
January 13, 2016	Research & Academics Steering Committee
January 18, 2016	Population Health Steering Committee
January 27, 2016	Research & Academics Steering Subcommittee
February 2, 2016	All Work Groups Meeting – Early Brain Development and Toxic Stress
February 4, 2016	Research & Academics Steering Committee

See ATTACHMENT D: Community Presentations and Materials

B. MEDIA INTERVIEWS

Table 8. MEDIA INTERVIEWS	
April 2, 2015	Proposed Merger announcement interviews
April 22, 2015	Kingsport Times News editorial board
April 22, 2015	WJHL editorial board
April 23, 2015	WCYB editorial board
April 23, 2015	Johnson City Press editorial board
May 7, 2015	WKPT editorial board
June 8, 2015	HealthLeaders Media
June 10, 2015	Community Workgroups announcement & interviews
June 11, 2015	Modern Healthcare
August 24, 2015	WJHL interview
September 16, 2015	Letter of Intent announcement interviews
September 16, 2015	Johnson City Press Forum and follow-up interviews
October 6, 2015	Interview with WCYB
October 12, 2015	Interview with Johnson City Press
October 16, 2015	Interview with the Bristol Herald Courier
October 19, 2015	Interview with The Business Journal
November 11, 2015	Interviews with The Tennessean and WJHL
November 12, 2015	Interview with The Tennessean
November 13, 2015	Statement provided to the Johnson City Press, Roanoke time and WKPT
November 16, 2015	Statement provided to WJHL
November 20, 2015	Statement provided to WJHL
December 1, 2015	Statement provided to WCYB
December 9, 2015	Statement provided to the Johnson City Pres
December 15, 2015	Statement provided to The Business Journal and the Johnson City News & Neighbor
December 17, 2015	Statement provided to WJH
December 23, 2015	Statement provided to The Post
December 28, 2015	Statement provided to the Johnson City Pres
December 30, 2015	Statement provided to WXBQ and the Kingsport Times-News
January 7, 2016	Media briefing for area media
January 7, 2016	Interview with Modern Healthcare
January 7, 2016	Interview with Kingsport Times-News
January 13, 2016	Statement to The Greeneville Sun
January 18, 2016	Interview with WCYB
January 27, 2016	Statement to WXBQ
February 3, 2016	Interview with Bristol Herald Courier
February 3, 2016	Interview with WCYB
February 9, 2016	Interview with WJHL
February 10, 2016	Kingsport Rotary Club (noon meeting)
February 12, 2016	Regional legislative breakfast

6. COMMUNITY GROUP MEETINGS

Leaders from both systems have also talked with community members throughout the region, in auditoriums, coffee shops and restaurants, local businesses, higher education centers, and other venues, to seek input on the new health system the Parties envision for the region. Through the Community Health Work Group initiative in partnership with East Tennessee State University (ETSU), more than 150 community members to date have participated in work groups focused on discussing four key areas for health improvement in the region: Mental Health & Addiction, Healthy Children & Families, Research & Academics, and Population Health & Healthy Communities. Additionally, in cooperation with the College of Public Health at ETSU and in connection with the Parties' goal to improve health care services through the new health system, the Parties have jointly sponsored and funded the region's most substantial community health improvement assessment effort to date. The Parties also conducted 10 roundtable meetings where more than 175 community members gathered to discuss important local health issues.

A. COMMUNITY HEALTH WORK GROUP MEETINGS

The Community Health Work Groups have served an important role in helping raise awareness of the proposed merger, solicit feedback from members of the community and discuss the factors in the region which lead to poor health outcomes. The schedule for these meetings is below and summaries of all of the meetings are included in this Exhibit: The Community Health Work Group Charters and Membership Lists are attached as other Exhibits to this Application.

Mental Health & Addiction Committee *(Meetings held from 9:30-Noon)*

- Thursday, August 20th, Millennium Centre, Johnson City
- Thursday, September 17th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, October 21st, Millennium Centre, Johnson City
- Thursday, November 19th, Southwest Virginia Higher Education Center, Abingdon
- Friday, December 18th, Millennium Centre, Johnson City

Healthy Children & Families Committee *(Meetings held from 9:30-Noon)*

- Tuesday, September 8th, Southwest Virginia Higher Education Center, Abingdon
- Tuesday, October 13th, Millennium Centre, Johnson City
- Tuesday, November 10th, Southwest Virginia Higher Education Center, Abingdon
- Tuesday, December 8th, Millennium Centre, Johnson City
- Tuesday, January 5th, Southwest Virginia United Way office (subcommittee meeting)_
- Tuesday, January 12th, Southwest Virginia Higher Education Center, Abingdon

Population Health & Healthy Communities Committee *(Meetings held from 9:30-Noon)*

- Monday, August 24th, Southwest Virginia Higher Education Center, Abingdon
- Monday, September 28th, Millennium Centre, Johnson City
- Monday, October 26th, Southwest Virginia Higher Education Center, Abingdon
- Monday, November 16th, Millennium Centre, Johnson City
- Monday, January 18th, Southwest Virginia Higher Education Center, Abingdon

Research & Academics Committee *(Meetings held from 9:30-Noon)*

- Thursday, September 24th, Millennium Centre, Johnson City
- Thursday, October 28th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, December 2nd, Millennium Centre, Johnson City
- Wednesday, January 13th, Southwest Virginia Higher Education Center, Abingdon
- Wednesday, January 27th, ETSU, (subcommittee meeting)
- Thursday, February 4, Millennium Centre, Johnson City

All Community Health Work Groups Meetings

- Monday, November 16 (9:00 – 10: 30), Millennium Centre, Johnson City, Topic: Accountable Care Communities
- Friday, December 18 (9:30 – 11:30), Millennium Centre, Johnson City, Topic: Impact of Opioids on Appalachia
- Tuesday, February 2 (9:00 – 10:30), Millennium Centre, Johnson City, Topic: Early Brain Development and Toxic Stress

B. COMMUNITY HEALTH ROUNDTABLE MEETINGS

More than 175 attendees participated in 10 roundtable meetings held from August to October in 2015. At these meetings, data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, **"What can you do to improve health in the community?"** At the end of the two rounds of small group discussion, notes were collected from the table moderators to be used for a final large group discussion to allow for further comment and clarification. Representatives from ETSU then compiled and analyzed this feedback and authored detailed summary reports included in **Attachment E**.

Included in **Attachment E** is a report summarizing the overall findings from the Community Health Roundtable meetings and a summary report for each individual Community Health Roundtable meeting.

The schedule of the Roundtable meetings is below.

Schedule of 2015 Roundtable Meetings
(Meetings for Community Members; meetings held from 5:30-7:30 p.m.)

- Thursday, August 13th, Tennessee College of Applied Technology, 425 TN-91, Elizabethton, Tenn.
- Thursday, August 20th, Southwest Virginia Higher Education Center, One Partnership Circle, Abingdon, Va.
- Tuesday, September 15th, Holston Hills Community Golf Course (Multi-Purpose Room), Marion, VA
- Thursday, September 24th, Tennessee National Guard Armory, 615 S. Main Street, Erwin, TN (Unicoi)
- Tuesday, September 29th, Russell County Conference Center, Lebanon, VA
- Thursday, October 1st, Food City Press Room, Kingsport, TN
- Tuesday, October 6th, Crooked Road Tech Center, Duffield, VA
- Thursday, October 15th, Bristol Motor Speedway, Bristol, TN
- Tuesday, October 20th, The Inn at Wise (Ballroom), Wise, VA
- Wednesday, October 21, United Way 2020 Summit with Robert Wood Johnson Foundation, Southwest Virginia Higher Education Center
- Thursday, October 22nd, Memorial Park Community Center, 510 Bert Street, Johnson City, TN

See ATTACHMENT E: Community Roundtable Meetings Summary Report (Includes Data from All Roundtable Meetings) & Community Roundtable Meeting Summary Reports by Community

C. SOUTHWEST VIRGINIA 2020 SUMMIT REPORT

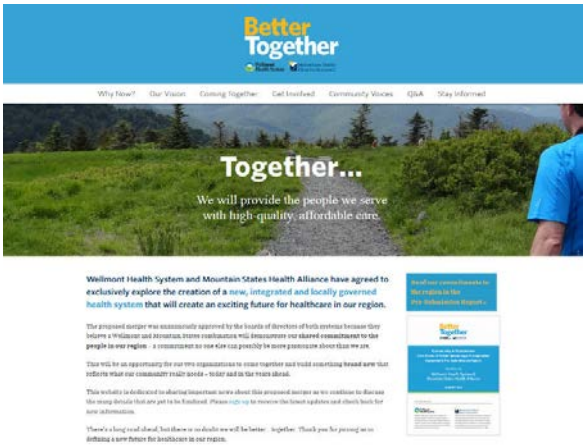
During the Southwest Virginia 2020 Summit, 65 attendees participated in a World Café style discussion around the question, "What can you do to improve health in the community?" At the end of group discussion, notes were collected from the table moderators, or "Table Hosts", to be used for a final large group discussion to allow for further comment and clarification. Representatives from ETSU then compiled and analyzed this feedback and authored a summary report included in **Attachment F**.

Attachment F includes a summary report from the Southwest Virginia 2020 Summit.

See ATTACHMENT F: Southwest Virginia 2020 Summit Report

7. BETTER TOGETHER WEBSITE --- www.BecomingBetterTogether.org

In April 2015, Wellmont Health System and Mountain States Health Alliance launched the Better Together website to serve as a central point for information on the proposed merger and to provide anyone interested with an opportunity to learn more about the proposed merger and ask questions or provide feedback. The website contains information about the process the systems are following to obtain a Certificate of Public Advantage (COPA) in Tennessee and a Letter Authorizing Cooperative Agrement in Virginia, including announcements, frequently asked questions and opportunity for comment and community involvement.



The website also includes important documents related to the merger, including the Pre-Submission Report, the Letter of Intent filed with both States, status reports from Community Health Work Group meetings, and the shared vision of Wellmont and Mountain States.

Following the filing of the applications for a COPA in Tennessee and a Letter Authorizing Cooperative Agreement in Virginia, the Parties plan to make the public portion of these applications available on the website.

A. QUESTIONS & ANSWERS (Q&A)

Since April 2015, the Parties have received through the website hundreds of questions and comments from members of the community and employees from both systems. Many of the "most frequently asked questions" have been published and distributed on the website, in Better Together newsletters, discussed in internal town hall meetings, and other community input venues.

Table 9 below includes a complete list of the Q&A from the Better Together website. The Parties will continue to update this page with new questions and answers throughout the application review and approval process.

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	**Answers**
What does this mean for existing contracts or relationships for services (including labs, etc.)?	Today, nothing changes as both Wellmont and Mountain States continue as separate and independent organizations. It's business as usual, and we're committed to keeping our valued partners and the community informed along the way. We do know that any existing contracts that extend past the official closing will be honored by the proposed new organization, and anything that affects clinical services will be carefully considered with input from our physician leaders.
Will nurses be involved in the planning efforts for the proposed new organization?	Yes, absolutely – there will be a number of ways nurses from both Wellmont and Mountain States will be heard through this process. In fact, we won't be successful in accomplishing what we hope to do without the support and input of our nurses. As the Integration Council continues to progress, it will activate functional teams that will provide recommendations related to the operations of a merged system. We will want nursing to be well represented and active on these teams, which will focus specifically on areas like clinical operations, academics and research, and population health. Throughout this process, we encourage nursing leadership to stay closely in touch with hospital leadership to communicate questions and thoughts from nursing staff. Meanwhile, we will continue to seek the input of our team members in a variety of ways, including this website, our newsletter, internal and external town hall meetings, and more. We recognize the vital role our nurses play every day but especially in shaping the future of our proposed new system, and we're committed to keeping our nurses updated on any opportunities to be involved.
How does this decision impact ETSU?	We believe our proposed new organization would positively impact East Tennessee State University and other academic institutions, as it would allow us to further advance clinical education in the region and to be more competitive in pursuing research dollars currently flowing elsewhere nationally. In fact, the president of ETSU will also serve as an ex-officio member of the new system's Board. Both Mountain States and Wellmont have been forced to reduce residency positions in recent years. We believe this partnership can help reverse that

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	**Answers**
	trend. We would partner with ETSU and others to strengthen the pipeline of physicians and allied health professionals and to attract research jobs and investments in our region. In addition, ETSU would help to conduct a substantial comprehensive regional health needs assessment to address health gaps and disparities, which will help shape the future direction of the potential new system and establish its priorities.
Which EHR system will be used by the combined entity?	That is a major decision that has both strategic and clinical implications, and no decisions like this would be made until after the transaction closes (expected no earlier than the end of 2015). We will include significant input from our physicians before making any major decisions that will impact clinical care. What we do know today is that our combined organization would have a single EHR platform to ensure our facilities and providers work as seamlessly as possible with each other. We promise to share more information as soon as it's available.
Will the community be able to provide input regarding the new name of the future organization?	Yes! As we explore creating a new, locally governed health system, we want to be sure the community – along with our own team members and physicians – has input in shaping it. We are not quite ready to begin the process of naming or branding, but stay tuned for how to chime in.
What is a COPA, and how does the state decide whether to grant a COPA?	A COPA (Certificate of Public Advantage) in Tennessee is the effective approval of a cooperative agreement between two hospitals or health systems. It authorizes the parties to merge and directs the state to actively supervise aspects of the new health system to ensure it continues to benefit the community by providing healthcare that is affordable, accessible and high-quality. In Virginia, we will pursue a cooperative agreement process.The state evaluates the potential benefits of a cooperative agreement and considers whether one or more of the following benefits might result from the cooperative agreement, and whether those benefits outweigh any possible disadvantages: • Enhancement of the quality of hospital and hospital-related care provided to citizens • Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities • Gains in the cost-efficiency of services provided by the hospitals involved • Improvements in the utilization of hospital resources and equipment • Avoidance of duplication of hospital resources
What has been announced?	Wellmont Health System and Mountain States Health Alliance have agreed to exclusively explore the creation of a new, integrated and locally governed health system designed to be among the best in the

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	**Answers**
	nation and to address the serious health issues that affect our region. The new health system would bring together the capabilities of both organizations – under a new name – to serve the region and result in unprecedented quality and value.
Who made this decision?	The decision to explore a merger was made by the Wellmont and Mountain States boards of directors, and reflects a vision they developed following more than a year of merger discussions, internal analysis within each system and thoughtful conversations in the community. It reflects the desires of both organizations to ensure our region has access to the highest quality, affordable healthcare, and that we are able to meet the ever-changing needs of our communities.
Why was this decision made?	In addition to the significant headwinds for hospitals nationally, our region suffers from serious health issues that need to be addressed. We have some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country. We are experiencing an epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment. And, we admit more people to the hospital per thousand than most other areas of the nation. The cost of this poor health is not sustainable. Despite the high-quality care both systems provide today, there is more we can be doing to contribute to improving the health of our region. We believe that by working together in an integrated system, we could redirect spending away from wasteful duplication that has not added value, and invest in what evidence has shown will help make our region healthier while controlling costs and making healthcare more affordable.
How will Wellmont and Mountain States bring distinct organizations and cultures together?	Culture and heritage are critically important to both organizations. That's why we are creating a joint board task force, an integration council and a clinical council. Over the next many months, our board members and executive and physician leaders will be investing themselves in the work of exploring how to weave our operations and cultures together, so we benefit from the best of both.
Will projects planned be put on hold while this merger is explored?	Today, nothing changes as both Wellmont and Mountain States continue as separate and independent organizations. It's "business as usual" for both of us.
What does this mean for our community?	This would be a significant step forward for patient care, wellness, affordability and health education in our region. We would: • Work to eliminate unnecessary duplication in our operations, enabling us to invest more in better coordinating patient care, improving quality and enhancing access throughout the communities we serve; • Invest in high-level specialty services, allowing more people to receive the care they need close to home; • Work with ETSU and our academic partners to conduct a comprehensive regional health needs assessment; then work hand-in-

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	**Answers**
	hand to tackle some of the most important health issues our region faces, including high rates of smoking, obesity, physical inactivity and the adverse health effects that follow, such as high blood pressure, diabetes, heart disease and cancer; • Work to improve access to substance abuse and mental health services in the region; and • Work with academic institutions, such as ETSU, to strengthen the pipeline of physicians and allied health professionals, and to attract research jobs and investments in our region.
What is the approval process for this merger?	Upon completion of due diligence, should both systems vote to go forward, Wellmont and Mountain States will execute a definitive agreement, which will be followed by a process to obtain Tennessee and Virginia approvals of the merger. This will likely take us through the end of 2015. Together we will pursue a Certificate of Public Advantage (COPA) in Tennessee and a cooperative agreement in Virginia, which would permit the merger to go forward and establish a process for the states to supervise our proposed new organization. This agreement will ensure that the people we serve receive the highest level of care at an affordable cost.
What happens next?	Following a definitive agreement, we will enter a government approval phase that will likely take us through the end of 2015. During this time and until the moment of closing, both organizations will continue "business as usual" as two separate and independent organizations.
Where can I learn more/stay updated?	We will be communicating regularly over the coming days, weeks and months. Stay tuned. And, be sure to check back here for the latest updates.
What are the plans for the future of pediatrics care?	We see great opportunity to enhance and expand access to pediatric services through our proposed merger across the region. What that looks like specifically is part of the planning work ahead as we first identify gaps in what our communities need versus what either of our organizations offer today and can improve through the proposed merger. We look forward to sharing more information as our planning efforts unfold.
Are there plans to close one of the two hospitals in Norton, Virginia?	There are no plans to close any hospitals. The services and programs offered by both organizations through our hospitals and other locations are always evolving in ways that reflect the input of our physicians and the needs of our patients. Long-term, the new organization will conduct a comprehensive health needs assessment to identify opportunities for new community-based resources and possibilities that don't exist today for our employees and communities.
Won't we lose competition by combining Mountain States and Wellmont?	Actually, with this merger, our patients and our region will have access to more choices and healthcare options than they do today. By combining our resources, we can draw more specialists and add new services for which people now have to drive hours to find. In addition, this potential

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	**Answers**
	new organization would involve the institution of a Certificate of Public Advantage or COPA in TN and a cooperative agreement in VA, which establishes enforceable commitments to guard against effects from any loss of competition. A COPA in TN / cooperative agreement in VA will mean that the health system must meet commitments in driving down unnecessary costs, keeping care affordable, improving quality of care, enhancing access and benefiting the communities we serve.
How will patients benefit once our two organizations come together?	Here are just a few of the ways our proposed future system will serve you, our patients: • We'll invest in expanding access to care and services, while also maintaining access in our rural communities, so you can get the care you need close to home – at a cost that's affordable for you and your family. • Wherever you go in our integrated system to receive care – no matter which doctor you see – your care team will have your medical history at their fingertips through a systemwide technology platform, ensuring the care you receive takes your overall health into account. • Together, we'll be better able to coordinate your care between your doctor, the hospital and outpatient services like home health and pharmacy – improving the quality of care you receive and creating a superior experience every time you visit us. • We'll work on improving access to important services that so many people in our region need, like substance abuse treatment to stop the cycle of addiction and improved mental health services. • Working with East Tennessee State University, we'll identify and tackle head-on important health issues in our region, like heart disease, addiction and diabetes. • And much more.
Will there be any facility closures?	Today, we are still very early in exploring the specifics of what our future organization will look like. What we do know today is our proposed new organization would be committed to providing people the care they need close to home. There will be changes throughout the new organization in order to offer new and different services, depending on what the community needs. We promise to share more information as soon as it's available.
What color scrubs will the employees of the new system wear?	At this point, there are no plans to make any changes. In the future, any changes like this would be determined with input from clinical leadership in the hospitals.
Once the new system is formed, will employees receive tuition discounts or	Our goal is to ensure we have a culture that attracts and retains outstanding team members, and provides opportunity for professional growth. These kinds of opportunities will be discussed at the appropriate time, but the objective will be to ensure a learning

Table 9. Q&A FROM BECOMINGBETTERTOGETHER.ORG AS OF 2/9/16	
Questions	**Answers**
reimbursements because of the system's relationship to ETSU?	environment.
How will employee benefits be impacted (retirement, insurance, PTO, pension plan, etc.)?	We understand how important these types of questions are. Today, we are still very early in exploring the specifics of what our future organization will look like. What we can tell you today is that we would aspire to be one of the best healthcare employers in the country. Together, we would nurture a culture that promotes employee satisfaction and opportunity for professional growth. We promise to share more information when we are able.
Will employees be offered an early retirement option?	Today, we are still very early in exploring the specifics of what our future organization will look like. We promise to share more information when we are able.

B. PUBLIC FEEDBACK ON COMMUNITY ENGAGEMENT

Since April 2015, there have been nearly 15,000 visitors to the Better Together website, and more than 50,000 page views. Website visitors are invited to submit a question or comment through the site, and more than 200 comments and questions have been received to date. The previous Section A included the questions submitted through the wesbite. This Section summarizes and categorizes the questions as well as the comments received on the website.

These questions and comments are included in their entirety and organized below into the following categories:

- Community Health Work Groups ◦ Community Health Roundtables
- Process ◦ Operations ◦ Organizational Structure
- Services ◦ Access ◦ Value ◦ Choice
- Workforce ◦ Staffing ◦ Benefits ◦ Training
- General ◦ Miscellaneous

1. PUBLIC FEEDBACK: COMMUNITY HEALTH WORK GROUPS/ COMMUNITY HEALTH ROUNDTABLES

In the Fall of 2015, the Parties launched their effort with ETSU to conduct a series of in-depth discussions about regional health issues through the Community Health Work Group meetings and the Community Health Roundtables with a broad array of stakeholders throughout Southwest Virginia and Northeast Tennessee. These discussions drove a significant number (59) of comments and questions to the BecomingBetterTogether.com website related to the themes, "Community Health Work Groups." Additionally, more than 100 community members expressed interest in participating in the initiative through the website. The comments relating to the Community Health Work Groups and Community Health Roundtables are below.

Table 10. WEBSITE COMMENTS & QUESTIONS
Category: Community Health Work Groups, Community Health Roundtables

Date	Name	Question/Comment
6/10/2015	Meg Foster	I am having trouble submitting the link to learn more about participating in a Work Group; it keeps stating validation errors occurred. Please advise, I am interested in any of the 3 groups; Healthy children and families, research and academics, and/or population health and healthy communities.
6/10/2015	Susanna Ashford	I would love to participate in these work groups!
6/11/2015	Doreen Heppert	I have attempted several times to submit the brief form indicating my interest in the Population Health & Healthy Communities work group. I keep receiving an error message "Validation errors occurred. Please confirm the fields and submit it again." I have checked all fields but receive the same validation error.
6/11/2015	Pat Pope	Hello, I am interested in participating in the work groups. When I submit the form, it continues to return a validation error. Please advise.
6/11/2015	Ann Hylton	I am interested in the Healthy Children and Families and Research and

Table 10. WEBSITE COMMENTS & QUESTIONS Category: Community Health Work Groups, Community Health Roundtables		
Date	**Name**	**Question/Comment**
		Academics work groups. I am unable to submit via the electronic form. I continue to receive an error message. I live in Gray TN. Employer is Appalachian College of Pharmacy where I am assistant professors/ Clinical Pharmacist in the ED at Bristol Regional Medical center. Research and Academics: I am an assistant professor at Appalachian College of Pharmacy and a clinical pharmacist in the ED at Bristol Regional Medical Center. I am the residency program director for Appalachian College of Pharmacy and serve as a preceptor and residency committee member at Bristol Regional Medical Center. I used to work at the VA in Johnson City where I worked closely with members of the ETSU medical program. I feel that I am invested in the medical training in this region; physicians, nurses, pharmacists, and other sub-specialties. Healthy Children and Families: I am a mother to two children, 2.5 years and 8 months. I am also a strong breastfeeding advocate and a member of the local BABE coalition. I highly support the efforts of ETSU pediatrics with the Read N Play programs. I would like to see the work of ETSU/MSHA spread throughout the region to better serve all children. I have the input of a passionate mother and working professional.
6/11/2015	Chris Ketron	I am a Masters prepared psych RN with 15 years in psych and long term care. I am very interested in seeing better treatment options for our mentally ill and substance abuse patients
6/11/2015	Meg Foster	Hello, I still cannot submit on the work group page. I am interested in participating; I would like to be involved in community initiatives to improve health in all age groups. Currently I am a physical therapist and work in the hospital setting and see the effects of disease and unhealthy habits prolonging recovery of patients. I work with patients from all age groups, from tiny infants in the Neonatal intensive care to the elderly. One project that I recently worked on was coordinating the improvement of a healthier surgical candidate for total joint replacement surgeries. Dr. Carver, an anesthesiologist here at HVMC read a study that lowering BMI, smoking cessation, diabetic control and addressing undiagnosed sleep apnea can improve the recovery of patients undergoing surgery. We worked with the YMCA, physical therapists, Diabetes Treatment Center and HMG to emphasize prevention and a proactive approach to healthy living can improve outcomes and return people to independent community living. Improving community health has to reach across the continuum of care to maximize and improve the benefits of a healthy

Table 10. WEBSITE COMMENTS & QUESTIONS Category: Community Health Work Groups, Community Health Roundtables		
Date	**Name**	**Question/Comment**
		lifestyle. We have to meet people where they currently are and pave the way to optimize their health and pass it on to the next generation.
6/11/2015	Sue Prill, MD MBA	I serve as principal investigator for many of our oncology clinical trials and have been active in research for many years. I would like to be included in the research forums if possible. Thanks.
6/13/2015	Jennifer Miller	I am interested in participating in the Mental Health work group.
6/17/2015	Jeretta Johnson	I am so excited to hear about this in our area. We have a great need for this program.
7/8/2015	Catherine Brillhart	I am interested in participating in a focus group setting. Thank you.
7/8/2015	Gary McGeough	I would like to be a part of the Population Health and Healthy Communities Group
7/8/2015	Kenneth Little	I would like to participate in the Population Health and Healthy Communities work group. Thank you! Ken
7/8/2015	Kristina K. Morris	Unit Coordinator with the Southwest Virginia Medical Reserve Corps. Would be happy to serve on any of the workgroups.
7/8/2015	Mark Overbay	As a retired physician, a former Wellmont employee and current dean of the School of Behavioral and Health Sciences at King University, I would be happy to assist with the Research and Academic committee if any additional help is needed. Mark Overbay, M.D.
7/9/2015	Angie Hagaman	I would like to receive the newsletter, and if possible serve on the mental health and addiction work group.
7/9/2015	Alice McCaffrey	As the Director of the Sullivan County Anti-Drug Coalition, I believe this work is very important and would like to participate in any way that would be appropriate. This is an opportunity to build substance abuse prevention into the new practices and procedures that will be developed.
7/9/2015	Angelee Murray	I am the Founder and Executive Director at Red Legacy Recovery. I would like to serve on the Mental Health & Addictions work group.
7/10/2015	Rhonda Helton	Is it to late to submit my name for the Healthy Children and Families work group?
7/10/2015	Mary Anne Gibson	I consider myself a strong advocate for children and families personally and through my work at the YWCA Bristol via the early childhood programing for 28 years. I look forward to being involved with the Healthy Children and Families Work Group. Will I receive information or do I need to continue to check this website for scheduled meetings?
7/11/2015	Sara Ellis	As a special education teacher for students with multiple disabilities and having worked at the community level in the regional Head Start program (People Inc.) prior to the Bristol Public Schools, I have a great interest in accessibility of health care for our special needs population.

Table 10. WEBSITE COMMENTS & QUESTIONS Category: Community Health Work Groups, Community Health Roundtables		
Date	**Name**	**Question/Comment**
		Though there are some services available through a few local agencies, we are lacking in the accessibility of some of the specialized health care professionals/needs as evidenced by this population and their families having to sometimes travel well out of the region for treatment and ongoing care. Too, the wonderful health care providers we do have are uncomfortable or simply have not received adequate training in caring for the special needs population. With the capability of saving more micro-premies, the increase in identifying individuals with autism, and drug/alcohol affected babies, the health care system must address the ongoing challenges posed by these individuals.
7/13/2015	Doris Stickley	I would be very interested in working in this area. Our Health Education Series we did at the BPL for two years was very popular, and it dealt with public health and community health concerns. The Library is always a great partner when you want to get out information, too.
7/13/2015	James H. Bangle	Would like to be involved in Mental Health and Addiction Group. I am a retired Lutheran Pastor Licensed Clinical Social Worker in private practice for 23 years. Have been a Law Enforcement Chaplain for 33 years. Lots of other stuff. Thanks for your consideration.
7/14/2015	Rhonda Chafin	Second Harvest would like to be involved in the Healthy Children and Families group. Please keep us posted on upcoming meetings. Rhonda Chafin Executive Director Second Harvest Food Bank of Northeast Tennessee
7/14/2015	Wendy Welch	Greetings - I am a member of the SW VA Health Authority and director of UVA Wise's Graduate Medical Education Consortium. After hearing the presentation at the Authority meeting and discussion with my board, I'd like to offer services to the Research and Academic work group, if feasible for your needs. Thanks. My phone is 276-328-0249.
7/15/2015	Han Chuan Ong	Hello! I am the Dean of the College of Arts & Sciences at King University and I would like to be participate in the working group on Research and Academics. I have a doctoral degree in molecular biology and have been an educator for 10 years.
7/16/2015	Debra Quarles Mills	I would like to be a part of the working group for Healthy Children and Families.
7/16/2015	Cathy Galyon Keramidas	Hello, Dr. Kim Hale told me about the group and asked if I would be interested in joining and I am very interested. I am an associate professor of early childhood special education and I have worked for 10+ years with families of children with disabilities. Please let me know if I would be a good addition to the group. I look forward to hearing from you. Cathy

Table 10. WEBSITE COMMENTS & QUESTIONS Category: Community Health Work Groups, Community Health Roundtables		
Date	**Name**	**Question/Comment**
7/20/2015	Lisa Tipton	Families Free is a licensed Alcohol and Drug and Mental Health treatment provider. As Executive Director I am very involved in our treatment division and also the provider work for DCS in the North East region. I would like to participate in the Healthy Children and Families workgroup.
7/24/2015	Katie Baker	I'd like to sign up to serve on the Health Children and Families committee.
7/24/2015	Terrie Walker	Hello, I am the Director of Clinical Research at Wellmont CVA Heart Institute. Is there a possibility of being a part of the group or board for Research and Academics? Thank you. Terrie
7/28/2015	Joy Fulkerson	Is it too late to join a work group. I am most interested in Healthy Children and Families and Population Health and Healthy Communities. Thank you.
7/31/2015	Liz Sluss	I am willing to volunteer on this task force as a clinical leader in Womens and childrens . This affects my patient population almost daily
7/31/2015	Liz Sluss	I am willing to volunteer in this arena as there is a huge gap in our region for our children
7/31/2015	Liz Sluss	I see a huge disparity in the southwest VA and North east Tennessee region for services for children with disabilities, like a 4 month waiting list to have your child evaluated for developmental evaluation. Along with as a healthcare worker more and more substance abuse with MOMS and subutex even those in pain clinics the communication between providers is not there and in the end we are seeing fetal demises on the rise and feel it is directly contributed to the abuse and poor communication and guidelines to help the addicted. In example a mom on subutex is failing her drug screens by using multible types of drugs. They have no consequences or guidelines such as incarceration to protect the infant until delivery. While I dont agree that incarceration is the answer something must be done. To see a beautiful infant who dies due to the mom going into withdrawl or see the ones who live in pain is heartbreaking. With our merger and our region we must come together and do you see this happening?
8/5/2015	Sue Cantrell	are all four groups meeting at the same time?
8/5/2015	Terrie Walker	This is my RSVP to the August 13th meeting at TN college of Applied Technology in Elizabethton. Thank you. Terrie
8/5/2015	Carl Valenti	Would love to learn and participate in anyway to be a part of such a progressive idea.
8/5/2015	Linda Wright	We also need to direct our attention to mental health and drug and alcohol abuse issues in this region. I would advise bringing in leaders from Magnolia Ridge also. East Tennessee and Virginia population are seeing a lot more of alcohol and drug problems which is a problem in the region of Tennessee and

Table 10. WEBSITE COMMENTS & QUESTIONS Category: Community Health Work Groups, Community Health Roundtables		
Date	**Name**	**Question/Comment**
		Virginia. The crime rate is also skyrocketing, etc Some diagnoses cannot be treated with a medication. Thanks
8/6/2015	Kim Malone	How do I become involved in health care/concern group as a citizen? I think the information mentioned that you were looking for people to be in roundtable groups.
8/6/2015	President, Junior League of Johnson City	Our community impact area is women and children's health with a specific focus on prenatal care and substance abuse. Thank you for adding us to your newsletter!
8/8/2015	Adrianne Hess	My chief concern is with mental health care, but also I'm very concernwed about palliative care, esp. for the elderly who have an operation, go to a rehab, then have relapses, back to the hospital. What does Medicare cover, in Assisted Living facilities, both in Va. and in Tn?
8/9/2015	Mary Wiley	I am currently scheduled to work on 8/13/15 however I will try to get someone to cover part of my shift to attend the Elizabethton meeting. Traveling to Abingdon is just too far at this time from my location.
8/14/2015	Andrew S. Rhinehart	I'm sorry, but I will not be able to attend either of the round table discussions.
8/16/2015	Cathy Puhr	As a newly retired ARNP, and with experience in working with at risk populations, would very much like to be included in the public meetings scheduled by the hospitals
8/18/2015	Alice McDowell	I am signed up for the Thursday, august 20 meeting, but would like to change to the sept 15th, since I live in marion. let me know if this is possible.
8/18/2015	Kim Quiring	I am interested in helping with the Research work group. I have a background in spine research and a member of the Society of Clincal Research Associates. Thank you! Kim 423-277-7075
8/21/2015	Beverly Meadows	I signed up for the Research and Academics work group but have not been informed of a meeting date. Could you please provide? Thank you. Beverly Meadows, PhD, RN
8/24/2015	Sandy Franklin	I would like to know which company will provide our dietary services (Aramark, Cisco??)
8/28/2015	Beverly Meadows	A colleague has been attending the Mental Health meetings where participants are very engaged. When are the future meetings for population health as well as research/academics?
8/31/2015	Rosalee Sites	I signed up for the meetings for Community health as well as the Psych/drug addiction groups. I have not heard of any meetings times/dates. have they strted yet?
9/20/2015	Elbert Dean Ray	I know that maybe this merger is and or will work on these problems in our society with the drug and substance abuse patients but as an employee of Wellmont something needs to be done now and would ask

Table 10. WEBSITE COMMENTS & QUESTIONS Category: Community Health Work Groups, Community Health Roundtables		
Date	**Name**	**Question/Comment**
		that someone would address these problems as they are now. Putting off what you may do is not solving what is happening at this present time. We need someone to do something now because it is causing a big problem within the hospital setting of helping very sick patients and then throwing in the druggies that disrupt the whole hospital environment and staff, who are not trained and know how to handle these people. Nurses are hired to take care of sick patients period, not drug addicts. We have a very big problem that needs to be addressed in the present time not down the road. Please work on this problem. Thank You
9/24/2015	Trudy Hughes	So excited about the work to address health issues in a wholistic and seamless fashion... Please keep me updated! Thanks!
9/25/2015	Bee Stuart	Kim Short will be coming with me. Her email address is ksshort03@gmail.com. Thank you
9/30/2015	Dennis Golob	Would you please cancel my reservation for the Oct 1 Kingsport meeting. Sorry.
10/1/2015	Rosalee Sites	i cannot attend the roundtable meeting this evening as i ended up with a conflict.
10/18/2015	Bill Francisco	The City of Johnson City has committed 28 acres to develop an environmental education park on King Springs Rd. n/k/a "Jacob's Nature Park at Sinking Creek." The State of Tennessee has committed funding to wetlands expansion and educational signage to address the E. coli in Sinking Creek. This community has donated nearly $30,000 through four years of annual fundraising with the "Jacob Francisco Memorial Century & Awareness Walk." Those funds are being spent to build a handicap-accessible bridge over Sinking Creek at the park. The development still requires $30,000 to build a pavilion with a living roof that will function as an outdoor classroom; $50,000 for wetlands boardwalk; and $30,000 for an additional bridge to link hiking trails with intended wetlands boardwalk. The non-profit organization, Boone Watershed Partnership, and the City of Johnson City have been working together to develop this little city park in a neighborhood surrounded by young families and seniors in low-income housing initiatives and next door to a group home for adults with intellectual disabilities. This venture merits investment consideration by MSHA/Wellmont as it addresses public health concerns of water quality, childhood obesity, and recreational access for seniors and intellectually disabled neighbors.

Table 10. WEBSITE COMMENTS & QUESTIONS Category: Community Health Work Groups, Community Health Roundtables		
Date	**Name**	**Question/Comment**
		I will be out of town during the public forum at the Memorial Park Community Center on October 22, 2015; otherwise, I would attend to present this opportunity for tangible investment in the public health of Johnson City. More information about the development may be found at www.jacobfrancisco.com and contacting me at my email address provided above. Thank you for any sincere consideration in this venture.
10/19/2015	Ida Mullins	I am very interested in the initiatives being planned for our community. Please provide me with any information that may describe the progress of the community health initiative. Thank you in advance for your attention.
12/7/2015	Mina McVeigh	I am interested in attending the Mental Health and Addiction Working Group. Do I need to RSVP or register?

2. PUBLIC FEEDBACK: PROCESS, OPERATIONS, ORGANIZATIONAL STRUCTURE

Parties received 32 comments through the Better Together website related to the Tennessee COPA/Virginia Cooperative Agreement process, current or future operations and/or the organizational structure of the proposed new health system. The Parties understand that the proposed merger and cooperative agreement process is unique, and they have worked to address these themes on the Better Together website, in the Pre-Submission Report and in the extensive information provided by the Parties in the Tennessee COPA and the Virginia Cooperative Agreement applications. The comments relating to Process, Operations and Organizational Structure are below.

Table 11. WEBSITE COMMENTS & QUESTIONS Category: Process, Operations, Organizational Structure		
Date	**Name**	**Comment**
4/2/2015	Zilipah Patton	What are the future plans for involving nursing leadership such as a CNO at the highest level of the leadership team. I know there is a President, CEO, COO, and CFO. However, with this being healthcare it is vital to include clinicans such as a CMO and CNO. Not only for decision making, but advocay and more. Thank you!
4/2/2015	Zilipah Patton	What are the future plans for involving nursing leadership such as a CNO at the highest level of the leadership team. I know there is a President, CEO, COO, and CFO. However, with this being healthcare it is vital to include clinicans such as a CMO and CNO. Not only for decision making, but advocay and more. Thank you!
4/2/2015	Michael	How about Highland's Wellness Heath System or (Alliance) for a name?
4/3/2015	John Kerber	Do you have any thoughts on what the new system will have to do to meet the COPA conditions in TN and VA?

Table 11. WEBSITE COMMENTS & QUESTIONS Category: Process, Operations, Organizational Structure		
Date	**Name**	**Comment**
4/3/2015	Tom Conkle	Just curious as to what the combined health care system will be called. I understand it will not be Mountain States or Welmont. When will the new name be announced?
4/3/2015	Adam Honeycutt	Can we name the new group the Appalachian Regional Health Partnership?
4/3/2015	Julia Blair	Where do we submit new name suggestions/ideas? Novus: latin for novel, extraordinary, a new thing. Precedo: latin to surpass, excell. Coactum: latin to bring together, to drive.
4/7/2015	Shane Morgan	I think allowing the employees from both systems the opportunity to submit suggestions for the new organization name would 'jumpstart' the excitement of the merger with the employees. Is this a possibility?
4/16/2015	April Hodges	Our pharmaceutical reps have voiced concerned about being able to come into the different offices as Mountain States doesnt allow them in. Will reps still be allowed to come in to meet with the providers?
4/16/2015	Sharon Sogioka	Will any of the computer systems or software commonly used by either company end up changing?
5/6/2015	Pamela Hartgrove	Why are there no nurses on the merger board? Nursing is the biggest profession in the hospital and it appears that input from nursing has not been sought. There is no discipline better prepared to speak regarding patient needs than the bedside nurse.
5/6/2015	Tina Strong	Will there be any type of Employee Committee to review what's being decided upon that affects our processes / or to review and question what's going on in the merger process from employee's standpoint?
5/7/2015	Linda Coffman,RN	At what point will employee representatives be involved in the merger process?
5/24/2015	Teresa Stephens	Thank you for creating this website to share news of the merger. I am unable to find how nursing will be represented in this process. As leaders in healthcare and coordinators of patient care, the nursing staff at both organizations represent a large percentage of employees and contribute extensively to all areas of services. I encourage you to consider the addition of these important team members to your leadership team. Sincerely, Teresa M. Stephens, PHD, MSN, RN, CNE University of Tennessee College of Nursing and The University of Tennessee Medical Center (Blountville, TN Resident)
6/2/2015	Beth Fraley	where do the billing offices fit into all the planning? Are we going to be shifted around to merge into the MSHA office in Johnson City or will they come to Kingsport/Bristol or will we meet in the middle somewhere and form a new office?
6/2/2015	Patti	How are the nurses being chosen to be a part of the Integration Council?

Table 11. WEBSITE COMMENTS & QUESTIONS Category: Process, Operations, Organizational Structure		
Date	**Name**	**Comment**
	Martin	
6/3/2015	Leslie Gilliam	One of our Johnson City facilities has heard several rumors; that we have already merged, Wellmont was purchased by MSHA, that it didn't matter if a patient went to a MSHA facility over a Wellmont facility that we were all one...just to name a few. On a recent marketing trip, several offices confirmed they had told patients this because they thought that was the truth...they also said that is what they heard on the news (which we know that is not true, but that was the perception taken). Is there any way that our Council can clarify this with all parties? Thank you.
6/10/2015	Ken Fleenor	Will the new entity continue to use the Virginia state police helicopter to take away revenue generating business from present vendors of helicopter services to MSHA and Wellmont?
6/26/2015	Rose Luster	What role, if any, does the federal goverment play in this descision?
7/8/2015	Connie Garrett	Will potential merger of insurance carriers influence merger of Wellmont Health System and Mountain States Health Alliance?
7/14/2015	Spencer	How large (number of providers) will the combined system be, and how will that compare to other regional systems?
8/21/2015	Beverly Meadows	I was curious as to how nursing would be represented in key elements of your new organization. I had not seen mention of their participation on major committees.
8/28/2015	Beth Fraley	What will this mean for the billing department? Rumors fly around and the one that is worrying some of us is that you'll outsource the billing. Also will we continue using our new expensive computer system or will there be another one that we will be using
9/23/2015	Elbert Dean Ray	I have sent a few of my concerns to you but this time I have a question that I would like to have and answer to. If better together is what the main point is Together then why is it that between Holston Valley and Bristol Regional, two of the largest Hospitals in the area, that the same policies are not the same. If something at Holston Valley is doing then why is it not being done or tried at Bristol Regional. I have heard of things that are being done at Holston Valley that could help at BRMC but are not being done at BRMC. Why is that I want to know?
9/24/2015	Eric Vaughn	My understanding is that someone submitted these questions and have not seen or gotten a response. I heard Anthem was the biggest holdout and weren't in favor of a monopoly. Is this still the issue? And now for the rumor of the week. We have heard that they have hired someone to replace Chris Spencer and he is the same person that is over the new company Intellihartx here in Kingsport. The rumor we're hearing is that our jobs are going to be outsourced to this company, is this true?
10/28/2015	Loren McDougall	Hello, Will investors have access to the term sheet or any other documents that specifically relate to the proposed financial landscape of the newly integrated entity? Financial consideration and change in capital structure are two areas I would like to have more insight into.

Table 11. WEBSITE COMMENTS & QUESTIONS Category: Process, Operations, Organizational Structure		
Date	**Name**	**Comment**
		Thank you, LM
12/2/2015	Rover	Look I did not want to give my name or email, but there are a couple of things that need to be addressed. First of all, this website needs to be updated. Please include the public meetings that were held and inform us of the questions that were asked and how you responded to them. some of us want to know. What is ETSU doing? Aren't they supposed to be doing some great study of the area to help with this merger? How is that study going? What efforts is ETSU making currently to assess the needs of our community. There is currently a group interested in actively stopping this merger, talk about it. Address it. Who is behind it. how are you going to address it. Why do you think they are doing it. Does this organization have any merit? What can we do as employees if we do not agree with this group to combat the errors in their message? We all should know by now that the FTC is involved with both Hospitals about this merger. This is because of the media. Don't you think you should give an update to this update or to the employees?
12/10/2015	John Thomas	Can we have some news about becoming better together? We have not heard anything about becoming better together. Thank you.
12/29/2015	John Thomas	I recently emailed a question about the latest news. I have yet to receive a responce. I as a member of the community that uses Holston Valley and Wellmont Medical Associates exclusivly I think you owe the public and myself some updates. It is piss poor management of a website if you can not respond to an email. I hope that it is not an indication of how the new company will be run. I expect to hear from you soon. Thanks, John Thomas
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12/31/2015	Beth Fraley	We haven't heard anything about the merge in several months (sometime around early summer if I remember right). Now all of a sudden there's an article about the merge and things didn't progress like they were suppose to by fall of 2015. THis was in the newspaper

Table 11. WEBSITE COMMENTS & QUESTIONS Category: Process, Operations, Organizational Structure		
Date	**Name**	**Comment**
		yesterday. It was our understanding that before anything went public we as Wellmont employees were suppose to be told first. Why are we not hearing ANYTHING and why all the secrets still? This affects us all, don't you think we need to know as well? Put yourself in our shoes, you'd want to know.
1/6/2016	Debbie Stidham	When is the target date for the merger?

3. PUBLIC FEEDBACK: SERVICES, ACCESS, VALUE & CHOICE

The Parties received 26 comments and questions related to Services, including availability, access, value and choice that will be offered after the merger. From the beginning, leaders at Wellmont and Mountain States have been committed to finding a solution to the region's unique and significant health issues that will expand access and choice, improve the quality of care and stem the growth of health care costs. The Parties have addressed these issues in the Pre-Submission Report and in the extensive information provided by the Parties in the Tennessee COPA and Virginia Cooperative Agreement applications. The website comments relating to the Services are below.

Table 12. WEBSITE COMMENTS & QUESTIONS Category: Services		
Date	**Name**	**Question/Comment**
4/2/2015	Heather Helvey	What does this mean for Cardiology,and Urgent Care, especially in Abingdon? Since MSHA is notorious for cutting employee positions, how many are going to be cut due to this merger? This merger gives no choice to patients now. Patients will leave the area to seek doctors and treatments.
4/2/2015	Bruce Jones	Will Norton Community and Mountain View Medical Center both remain open (Norton, VA)? The rumor is that NCH is expanding their ER so MVMC can close.
4/2/2015	Donna Davis	What will happen to the two different sets of physicians who are in the Abingdon area competing against one another (i.e., heart specialists, family practitioners, orthopedists, etc.?
4/4/2015	Kim Roop	Excited about potentials, yet anxious about unknowns. Concerned about duplication of services..specifically level 1 trauma designation. Any thoughts?
4/5/2015	Brandon	I am concerned that the merger will bring a lack of competition and "choice" for patients in their health care. What reassurance do we have that a monopoly in regional healthcare is beneficial to us? Also, what are some reference sources for the declining inpatient volumes in this region, given that "we have some of the highest rates of cardiovasulcar disease, diabetes, and pulmonary diease in the country"?

Table 12. WEBSITE COMMENTS & QUESTIONS Category: Services		
Date	**Name**	**Question/Comment**
		I feel our volumes have increased rather than decreased based on my caseload at the hospital (I am in the therapy department).
4/6/2015	S. Gail Hess	Will the merger affect the VA facility? Right now anyone who needs to be transferred somewhere else goes to Johnson City. Will the patient now have a choice of Johnson City or Holston Valley?
4/7/2015	TJ Kelly	Wellmont already closed Lee Regional in Lee County and left us without a hospital. There are 2 hospitals in Norton. Do you plan on shutting one of them down when this takes place? I assume that if you do it will be Mountain View as you've been pouring money into Norton Community...
4/8/2015	Kellie Winters	I know there is still a lot to be determined yet regarding jobs, but we are all curious about the status of the labs. MSHA owns their labs but Wellmont does not. Is it the plan to have all of the labs fall under the ownership of the new system, will MSHA labs go to Quest, or will they remain separate? There is always concern when a merger happens, and the wellmont labs have been through several mergers and acquisitions recently. It would be nice to know which direction we may be headed. Thank you
4/8/2015	Stephanie Scissom, RN	Being a part of the mental health team at Woodridge, a lot of focus is on this type of care, is it possible that a new facility will open possibly in Kingsport?
4/9/2015	Debra Hanshew	With this new health system being formed, what will happen to the laboratory portion of Wellmont? Currently, they contract to Quest whereas MSHA owns Synergy. Someone said that they were told that this would be a good opportunity for Quest - but has Quest been notified so they can begin their own decision making to decide if they would even want to pursue? Is there a possiblilty that the new system could buyout all current Quest lab employees and convert the labs into Synergy (or a newly named laboratory services)?
5/14/2015	Macon Hogan	What are the plans for pediatrics care at Bristol Regional and Holston Valley?
6/2/2015	Jessica Beeler	Will lab still be Quest?
6/2/2015	Tim Nuckols	What is the expected impact of the merger for Marsh Regional Blood Center?
6/3/2015	Donna Sexton	I am from Southwest Virginia. I have had many people outside of the hospital express a deep concern about this merger. Many of these people bypass Johnston Memorial Hospital & Smyth County Community Hospital because they do not wish to go to a MSHA hospital. What will happen to their options when BRMC becomes a part of MSHA? Also, when Wellmont first mentioned finding someone to merge with we were told it would be someone who is financially sound? Is MSHA financially sound or" in deep debt " as most people feel they are? If they are in financial trouble why did Wellmont choose a merger with them?

Table 12. WEBSITE COMMENTS & QUESTIONS Category: Services		
Date	**Name**	**Question/Comment**
		This is a real concern for the people of Southwest Virginia. One that needs to be addressed by the leadership of Wellmont & Mountain States.
6/3/2015	Ty	Kingsport, Bristol, and Johnson City each have their own daVinci Robotic Surgery prrograms. How will each of these programs be affected once the merger takes place? When the news first discussed the merger, they interviewed the Mayor of Kingsport, and he said that each hospital had a million machine that would need to be centralized to be more cost-effective. Is this the current plan to centralize into one daVinci program, or will the current programs remain intact?
6/4/2015	Mary Wiley	Are there any plans to set up additional Psych facilities or departments to alleviate the load and assist the community members in need of these treatment facilities? We see so many patients who are in need of assistance that unfortunately spend upwards to 72 hours in the ER waiting for placement because there is no where for them to go. It is a real problem that I hope would be considered in the future. Thank you for your time.
6/23/2015	Edie Lane	Has there been discussion of possible Behavioral Health services being brought back to Kingsport?
8/2/2015	Jennifer Divers	Are you aware of the Roanoke Times article about Lee County, VA and its attempt to reopen their facility? It casts a negative light on Wellmont and portrays an antagonist relationship between the two systems? Would you comment on that? And also would you assist in reopening the Lee County facility?
8/6/2015	Lynn Shurtleff	Truthfully, I am not a fan of MSHA. I have had horrible experiences at JCMC and Sycamore Shoals ER. I have told my surgeon if the only place he can do replacement surgery is JCMC, I will find another surgeon because I will not go back there. Disorganization, under staffing, poor equipment maintenance and poor care. I do not believe that lack of competition is a good thing and know that where my parents live in FL that has only 1 system, you have no choices and no options except to leave the area, which the elderly and lower income cannot do. I haven't heard anyone say they think this is a good thing except those that stand to benefit from it. As an insurance agent that specializes in Medicare coverage with almost 500 clients, I know those in the Bristol area do not want a MSHA hospital and the recommended hospital is Holston Valley. Fear is that if MSHA takes over, we will lose doctors that want nothing to do with MSHA and the level of care will drop and the patients will suffer.
8/15/2015	Marty Landis	What you are doing is called a MONOPOLY and, by definition, reduces the choices for the consumer. It SUCKS!
8/27/2015	Tabetha	What are the plans for the outpatient cancer centers of both

Table 12. WEBSITE COMMENTS & QUESTIONS Category: Services		
Date	**Name**	**Question/Comment**
	Davis	companies?
8/28/2015	Beverly Meadows	Are there plans to recruit geriatricians to the area?
9/1/2015	Martin Ruppel	To receive Better Together newsletter. One question how will this merger effect two hospitals in Norton , VA and any effect on LPH Big Stone Gap , VA.
9/17/2015	Beth Fraley	in our last town hall meeting we when ask about insurances and their roll in our merge we were told that most were ok and in agreement with the merge but some including Anthem were not on board yet. Have all the insurance companies come "on board" with the merge yet? With the letter of intent being filed I would hope so. Anthem is a big provider around here and that would cause a lot of issues with a lot of people who would be patients at the new formed company.
10/12/2015	Danny	I would guess people are going to be upset if they have to travel to another location for specialty services. How can money be saved without consolidating some specialties?
10/22/2015	Carole	How will this merger not represent a " MONOPOLY" for southwest va. and east tennessee ?

4. PUBLIC FEEDBACK: WORKFORCE

The Parties received 39 comments and questions related to workforce issues, including recruitment, retention, staffing, benefits and training. The Parties understand that the ability to attract and retain a robust workforce is vital to the proposed new health system's success. Reflecting the Parties' vision to become one of the best health system employers in the country and one of the most attractive health systems for physicians and employee team members, they have addressed these concerns in both the Pre-Submission Report and in the extensive information provided by the Parties in the Tennessee and Virginia applications. The comments relating to the Workforce are below.

Table 13. WEBSITE COMMENTS & QUESTIONS Category: Workforce		
Date	**Name**	**Question/Comment**
4/2/2015	Margie Fitzgerald	I know from the Town Hall meetings that seniority will be kept, my two questions are: will FMLA that does not expire till 2016 be kept as is, & will PTO hours accrued as of time of merger be kept ? Thank you
4/2/2015	S. Gail Hess	If employees, with either system, must be terminated, will there be an incentive offered for early retirement?
4/2/2015	Shanoah	There are so many rumors about jobs being eliminated. I left Indian Path Medical Center to come to Holston Valley in order to pursue my dream in the department I have always wanted to be in. At IPMC, the chance of career advancement was not an option due to management on the floor I was working on. I have been at HVMC for 2 years now and over a year

Table 13. WEBSITE COMMENTS & QUESTIONS Category: Workforce		
Date	**Name**	**Question/Comment**
		ago was able to finally transfer to my dream job and I love it. In our department, so many nurses are talking about job elimination. I can't imagine losing my job, because I am where I always wanted to be and am so happy and thriving and learning daily. It is so hard to find a job in the department I work for and if I lost my position with this merger would not have an option to go anywhere else, because it is owned by the same company. My husband and I are foster parents in the process of adoption and cannot move until the adoption is final this summer hopefully, if jobs will be lost with this merger, we will both have to move which would cause us to lose the children we have now. Then if we tried to become foster parents somewhere else, it would take a long time. I know at this moment job loss is a rumor, but we need to know the answer.I am a big fan of change and doing whatever it takes to make a better community and health care system and have tried to ignore all the rumors the past 6 months. At the same time I am secretly playing scenarios over and over in my head, because Wellmont employees both my husband and I, and we have to think what is best for our family. I know the Q&A page says this isn't decided yet, but please take into consideration that this is an answer people are depending on.Thank you.
4/3/2015	April Draper	I know a few people who work in the laboratories with Wellmont and I know that the lab staff is out sourced to Quest/Solstace. My question is how is this going to work going forward with the lab staff, will staffing become outsourced or once the contract with Quest/Solstace expires will the employess there be offered positions within the new organization? Also, I know that they do not have a dress code as far as scrub colors within their labs, are we going to continue with the colors we have or are we going to explore new options and perhaps a vote for new colors moving forward as a new organization? Thank you in advance for your response and taking our concerns into consideration.
4/3/2015	Patricia Rebmann	What will become of the Wellmont Pension Plan after the merger?
4/3/2015	Patricia Rebmann	Is there a possibility of an early retirement incentive being offered to employees nearing retirement age with 25-30 years of service?
4/3/2015	Tom Conkle	What about our insurance coverage? Will we continue to have Crestpoint of would we hopefully be offered something better?
4/4/2015	Chris Ratliff	I recently started working at MSHA Norton Community Hospital. My start date was 11-1-14. I was wondering if I should be concered about losing my job. Should I be concerned?
4/4/2015	Chris Ratliff	I started working at Norton Community on 11-1-14. I am currently an RN on night shift and I am concerned that with this new merger that I may lose my job. Thank you.
4/5/2015	Randy	Will the employees who work at both Bristol Regional Med Center and

Table 13. WEBSITE COMMENTS & QUESTIONS Category: Workforce		
Date	**Name**	**Question/Comment**
		Johnson Memorial Hospital in order to make ends meet have to quit one of their jobs?
4/6/2015	Gilda W. McKinney	How will this merger affect our benefits as MSHA employees? What will we loose or how will benefit with this merger? Please state what will happen to our MSHA retirement.
4/6/2015	S. Gail Hess	Will the possible merger have any impact on employees who have retired and receive the HVMC defined benefit and insurance benefits?
4/6/2015	S. Gail Hess	If the merger should include termination for some employees, will there be consideration made for an early retirement incentive?
4/7/2015	Amanda Finley	Merger concerns I've been through mergers before (Pensacola, Fl), and I know how rumors spread. Many from the outside, not from the employees. I know that's crazy, but true. I have 2 concerns at this point. I may have more as time passes. 1. There are rumors that a nurses union will be initiated to protect our jobs, salary, etc. Please be prepared for this rumor. I've heard it several times in the last week. 2. The "No tobacco policy" will be eliminated. I hope this does not happen. Many patients have commented to me on how nice it is to not smell tobacco on the staff. It also keeps the staff on task, no more 30-45 minute smoke breaks. And our campus is so much cleaner. 3 years ago, I had to wade through cigarette butts to get to my car. I hope we do not return to the parking lot looking like an ashtray. We do NOT need to regress by eliminating that policy. Plus, it pays and saves in various ways to have healthier employees. Thank you from a concerned MSHA employee. Amanda Finley RN.
4/7/2015	Clara Dye	Will the merger affect our PTO that we have already earned and if so, how will it be affected. Thanks ! Clara
4/9/2015	Stacey Blevins	With the "new orginization" teaming up with ETSU, will this benefit employees regarding tution discounts/reimbrsement? If so, will this apply to our children or other family members?
4/16/2015	April Lunsford	Will Wellmont employees see a change in their pay to equal that of Mountain States employees?
4/16/2015	Beth	With a huge increase in the number of team members, I hope there will be a better insurance plan out there that is not such a high deductible, and covers more percentage. Is this a possibility?
4/16/2015	Betty Watkins	With a huge increase in the number of team members, I hope there will be a better insurance plan out there that is not such a high deductible, and covers more percentage. Is this a possibility?
4/17/2015	Karen	What does this merger mean for those of us who work for both hospital systems?
4/17/2015	Kassie Denney	How will nursing students who have the MSHA or Wellmont scholarship be affected? Will we still be accountable for three years with the new

Table 13. WEBSITE COMMENTS & QUESTIONS Category: Workforce		
Date	**Name**	**Question/Comment**
		company even if we signed a contract for Mountain States?
4/17/2015	Kim Barnett	Will our PPO's be able to serve us in the hospital again?
4/17/2015	Sylvia Garrett	Will we still have certain color scrubs to wear? It would be nice to have some autonomy in what we as nurses wear.
4/20/2015	Tiffany	When will employees of MSHA and WHS be able to transfer to each others facilities without losing senority?
4/21/2015	Marlene Allison	I understand you are in the early stages and do not have the answers to a lot of our questions. If jobs will be cut, offices be closed, ect. How much time will we be given in advance before this happens?
4/21/2015	Shara Bledsoe	My boyfriend is a PAC with MSHA, he chose to work with MSHA in his current position due to the pay being much greater than what was offered by Wellmont. His contract will end in May 2016, how will his income be effected by this merger? Kindly,
5/7/2015	Joy Allison	There are hundreds of people that work their regular job for one health system then work PRN for the other health system. For example an employee that works in the ER at Abingdon full time then in surgery at Bristol PRN. How will these employees be affected by the merger?
6/2/2015	Connie Puckett	What will happen when the merger occurs to employees who might be doing the same jobs at Wellmont & at Mountain States-in other words would seniority play a part in keeping their job if a duplicate of services happens?
6/4/2015	Linda Richardson	What about layoffs and cutting staff. This will be the only hospital from Smyth County to Johnson City. What will happen to to community as a whole when this occurs? Some will have to leave this area to find work.
6/5/2015	Terry Hedrick	Will current employees have to reapply for their positions?
6/10/2015	Barbara Wood	Will we have lower deductibles on our health insurance?
6/22/2015	Shirley Jupino	I think it will be a good step, if we at MSHA will have many more Doctors to go to from the Wellmont group. Will Creastpoint be the insurance offered?
7/29/2015	April	What will occur with pay scale? Wellmont and their contract holders pay scale is higher than that at MSHA. How will that affect pay rates across this new system and with current employees at both companies?
8/3/2015	Connie Garrett	Mountain States has had numerous "job fairs" recently. Will this mean less job opportunities for Wellmont employees if staff readjustments are indicated after the merger takes place?
8/28/2015	elizabeth wagner	Since we are now "better together." How about giving employees in-network privileges at Wellmont to MSHA employees.Any plans to do so?
8/28/2015	Margie	Both CEO's say there is a great need for healthcare employees, but,

Table 13. WEBSITE COMMENTS & QUESTIONS Category: Workforce		
Date	**Name**	**Question/Comment**
	Fitzgerald	cutting out duplication of services sounds like cutting jobs. Is that so?
8/28/2015	Mary Adams	If someone loses their job because of policy error and not for rehire. How would this effect future employment at another hospital if they are all owed by one coorporation? If not for rehire in the area you have lived most of your life, would be forced to move to another location, thus leaving family, friends behind and loss of revenue to the community.
9/29/2015	Brandon	Will there be any changes in jobs for the Wellmont Volunteers? As in less or the same?
10/13/2015	Leslie Gilley	I know this is an early thought at this time. This question is in regards to our 401K and 340B that we have accumulated over time. Can we have an option to roll this account over to a private finance company that has better options for mutual funds? We could make a higher % on retirement than we do now. If we chose to leave the company this would be an option. I have been with Wellmont 18 years and I have almost 5 different funds from changes we have made. I really don't need sixth one to keep up with.

5. PUBLIC FEEDBACK: GENERAL, MISCELLANEOUS

In addition to questions and comments received related to specific thematic topics outlined above, there were 28 questions and comments that are best described as "general/miscellaneous." To the extent possible, the Parties have addressed these concerns in the Pre-submission Report and in the Tennessee and Virginia applications. The general and miscellaneous comments are below.

Table 14. WEBSITE COMMENTS & QUESTIONS Theme: General, Miscellaneous		
Date	**Name**	**Question/Comment**
4/2/2015	Amy Callahan	please send news letter
4/2/2015	Jeanette D. Blazier	Congratulations! Let's make the articulated vision happen!
4/2/2015	Nathan A. Rowe, RN	Hope to come grow with you
4/3/2015	Mike Horton	I am an MSHA employee but please send updates to my yahoo account also.
4/3/2015	John Thomas	I just wanted to say that I am excited that these two great systems are planning on merging. I look forward to hearing all the updates.
4/3/2015	Myria Weems	Dear Team, I will have everyone in my prayers as you set out on this endeavor. I believe it will be done right and wtih integrity. It will make our region a better place to live and recieve top quality care. Thank you for allowing team members to be in the loop!

Table 14. WEBSITE COMMENTS & QUESTIONS Theme: General, Miscellaneous		
Date	**Name**	**Question/Comment**
		Sincerely, Myria Weems
4/6/2015	David	Looking forward to seeing this amazing transformation unfold. Thanks for including me in the conversation. Respectfully,
4/6/2015	Wanda Salyer	Thanks!
4/6/2015	Wendy Wakefield	Prayers for everyone. This will be a great merger for our region.
4/7/2015	Trish Riggan	I'd like to follow the updates.
4/10/2015	Wayne McKee	I believe this is a wonderful for the communities served by Wellmont and Mountain States Health Alliance. I worked for one of the sytems for over 3 years and felt and said then that the 2 sytems working together had the potential to do much more for the region working collaboratively than either could ever do operating independently. It'sgood news for the systems and the people of this region.
4/16/2015	Gary Mabrey	so proud of the courageous leadership shown by the Mountain States Health Alliance and Wellmont Health system...we will be the Cleveland Clinic or Mayo of the South.
4/17/2015	Kim Hall	Thanks for this info!
5/6/2015	Jason Stidham	Interested in receiving newsletter
5/8/2015	Jonathan Sanders	I'm looking forward to seeing what we can do with both health systems aligned.
6/1/2015	Tom Cooper	I'd like to receive the Better Together Newsletters. Thank you.
6/12/2015	Rebecca Henderson	I would like to be added to the newsletter list, please. Thank you!
7/17/2015	Beth Barnette	I own and publish the Kingsport Town Planner Community Calendar. I am working with Eastman and Healthy Kingsport to represent them in our publication. I'm interested in meeting with a marketing representative to make an introduction to our publication. Our full color print calendar is mailed free of charge to 30,000 Kingsport residents. I realize there are a lot of moving parts as you transition your organizations, but my purpose at this point is to introduce you to the community service we provide and allow you to consider what we can do to help in your branding/messaging going forward. I can send more information including an electronic version of our calendar with your permission. Please advise the best way to do so. Thank you. Beth Barnette, Owner Kingsport Town Planner Calendar 423.306.1237
7/20/2015	Ruth Armstrong	Hurry!
7/27/2015	Leah Smith	Please add me to your newsletter mailing list. I would like to attend your public meetings. Leah Smith
7/28/2015	James Daniel	Please add me to the list for your newsletter?
8/8/2015	Vicky Atwood	.....retired team member 12218....peace, good health, happiness to us all.....:-)

Table 14. WEBSITE COMMENTS & QUESTIONS Theme: General, Miscellaneous		
Date	**Name**	**Question/Comment**
	Hash	
8/9/2015	Tim Flannagan	Hello. I have a LIVE Streaming business located in the Tri-Cities and was inquiring to see if you would like to open up your round table meetings to a larger audience by LIVE streaming them. My fee is just $150 and the event will stay up online for 30 days. Please contact me for more information. Thank you, Tim Flannagan NuVision Marketing 423.366.0159
9/11/2015	Linda Burchette	I am a reporter for the Smyth County News & Messenger in Marion, VA. and am interested in receiving press releases from the organization.
9/23/2015	Dorothy A. Balhis	I would like to share this
10/5/2015	Joe Fuller	I would like to get on mailing list for the newsletter Thanks, Joe Fuller 628 Whitetail Cir Nickelsville, VA 24271 276-479-2148
11/23/2015	Kathy Horan	Good morning. I work in a marketing office for a hospital in New Jersey and am conducting research into branding agencies used by health care companies as part of merger integration communication. Can you share with me if Welcomont and Mountain States have hired a branding agency? And if so, did they develop the Better Together logo used throughout the merger Web site? Thank you. Kathy Horan Marketing Manager Monmouth Medical Center Long Branch, N.J.
1/5/2016	Brent Howell	Please add me to the newsletter and email list. Thank you.

C. WEBSITE COMMENTS ON PRE-SUBMISSION REPORT

The public was invited to review and provide feedback on the Pre-Submission Report, which was released and posted on the Better Together website on January 7, 2016. During the public comment period, which ran through February 12, 2016, the Parties received 28 comments and questions through the Better Together website.

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.

Date	Name	City	Comment
1/7/2016	David Winship	Abingdon, VA	I think it is important to specifically note the needs of elders in the community, and not expect that their needs are the same as others in an "adult" category.
1/7/2016	Jennifer Cordle		How would the merging of two hospitals affect our team members that work at both facilities? This will have a large impact on Radiology department and ER nurses more so than most. Would they(employees) be able to work at both facilities with a different job code or would it fall under Virginia law stating they could only work 40 hrs until overtime affects them and overtime is not usually a preferred thing to use. I ask because this will affect many family and workers at both facilities. If we follow Virginia law on this several people will lose one of their jobs and this could hurt our employees and local family. I appreciate the time and information. This is just a concern. Thank You Jennifer Cordle
1/7/2016	John Spear	Bristol, TN	I am an independent physician and see nothing in your pre-submission report stating that the proposed merged system (which would likely be the biggest or second biggest employer in our area) will not discriminate against independent physician practices when health system employees seek medical care from those independent physicians. In the past Wellmont has chosen to require their employees to pay more out of pocket for care from independent physicians than Wellmont-employed physicians. I see nothing stating the new system won't do it again. I cannot support any merged entity that will not provide a legally binding guarantee against this predatory practice, which Wellmont has been ever so willing to engage in before.
1/8/2016	Mack Mathews	Kingsport, TN	Merger seems to be right on task. Biggest deficiency of Mental Health Care is being addressed.
1/8/2016	Mack Mathews	Kingsport, TN	Appears the merger is right on task. Most glaring deficiency of Mental Health Care in the community is being addressed.
1/8/2016	Randy Hodge		I've heard that CrestPoint Health is being bought by a large insurance company.

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	**Name**	**City**	**Comment**
			Is this true?
1/8/2016	Debra		Will it really help with heart patients or will it cause new problems, in getting a dr that you can work with because alot of us live below poverty level as we are told by the dhs people so we don't have alot of extra money to spend on medicines, because it is either meds or eating or rent for our apt, we would like to hear about the costs for the procedures that we have to have.
1/8/2016	Thorne Olinger	St. Charles, VA	Wellmont flat out destroyed healthcare in Lee county by closing our hospital. Then fighting out county tooth and nail to give the hospital back to us. Now it wants to merge with MSHA to not have to file for bankruptcy? This is a very bad move on MSHA part. As of right now we lee county folks have lost so many of our citizens to death because of the long trip to critical care. Yes their is Lonesome Pine Hospital but all they do is ship them to Holston Valley Medical Center without regard of how bad those people were. And while we are talking about Holston Valley Medical Center and Lonesome Pine Hospital you put up a big talk about how good these hospitals are but the fact is they are on the borderline of flat out crappy. I think that if MSHA wants all these hospitals her in this area they should do a but out of wellmont and be done with them altogether. It would be really nice if this site would have a G+ page so everyone in this county "LEE" could let you know how of a bad idea this really is.
1/9/2016	Leton Harding	Wise, VA	Please add me to your email information list. Thank you Leton Harding
1/11/2016	Brant Kelch		Thank you for your consideration of these comments and questions.
1/11/2016	Rhonda Hall		Please include Clinical Nurse Specialists in your plans for post graduate training. This group of nurses could really rock if recognized as just as valuable to the team as a Nurse Practitioner or a Physician's Assistant.
1/12/2016	James Wallin	Kingsport, TN	I am very pleased to read the section "Enhanced Healthcare Services" which speaks to mental health issues, crisis management etc. I know that Woodridge is the only location for people who need both medical treatment and counseling but Kingsport is in need of a satellite facility as well. Reading the newspapers is confirmation of the need for this. Thanks for all your efforts. Regards. Jim Wallin
1/15/2016	Ashley Shaffer		Is there a plan to include investigator sponsored research studies of all disciplines as well as clinical trials? A research

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	**Name**	**City**	**Comment**
			partnership with ETSU should include all disciplines that are involved in patient care, and both qualitative as well as quantitative research. This would address the entire patient to help us understand how we could care for them more holistically. This is an awesome opportunity for interprofessional research and to raise the level of the science of patient care.
1/18/2016	Marty Sutton		I see the involvement of physicians at a very high level, at the table, as plans are discussed and decisions are being made. Is nursing there at the table at the same level? Nursing is a large percentage of the workforce that is present in all areas across the continuum, most times 24/7/365 being the eyes and ears for other disciplines as well as being advocates for patients. Will there be any nurses on the board of the new entity helping to shape policy and make decisions regarding care as well as workforce issues? It's understood that the physician brings patients to the system, but they need hands on care while there; care after the procedure, surgery, medication, etc.
1/19/2016	Georgita Washington		I have just a few questions/comments after hearing the overview of the pre-submission report and reading the document.
1/22/2016	Janita Adams		It is well-documented that mental health as a specialty service (i.e., community mental health) has poor reach to the population as a whole. About 50% of the population will struggle with mental health concerns in a given year. A vast majority will seek help in primary care, not mental health. These findings are supported by my own research in NE TN and SW VA. When primary care physicians refer to specialty mental health, only 17-30% of referred patients follow-through. Placing a mental health provider in primary care provides an opportunity for the concern to be addressed immediately in a coordinated fashion that is consistent with the medical home. Moreover, integrated behavioral health allows for patient consultation on any number of lifestyle changes that have significant impact on health (and some of the key needs in this region: smoking cessation, weight loss, increased physical activity, adherence to medical regiment, etc.). Finally, well integrated behavioral/mental health in primary care allows for prevention programming.
1/25/2016	Beth Fraley		Starting to hear A LOT of commercials on the radio about Carillion clinics needing nurses. At one time Carillion was one of the rumors for the merge, are they still a factor? Maybe merging with both MSHA and Wellmont if

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	**Name**	**City**	**Comment**
			something happens with the COPA/Cooperative Agreement issue?
1/26/2016	Jodi Polaha Jones		I urge the Joint Board Task Force and Integration Council to re-consider the existing plan for bolstering mental health services in the region. Models for integrating behavioral health into primary care have substantial evidence of effectiveness across the Triple Aim as well as growing policy support.
1/30/2016	Mae		How many ppl are going to be out of a job once the merger becomes a reality?
2/4/2016	Susan Laguardia	Kingsport, TN	I am very impressed with the comprehensive nature of the report and the specific commitments outlined in the six key areas that are to be implemented over the next ten years. I am especially interested in the commitment to improve community health. My work with nonprofit agencies in our community focuses on the physical and economic health and well-being of our citizens. I especially like what I read in the first key area about investment in children's health, wellness programs and the promotion of drug-free communities.I believe that the joining of our two medical systems will lead to cost efficiencies, increased access to higher quality medical professionals and potential better outcomes. My hope is that costs will be contained as competition between the systems is eliminated. I am in favor of the merger being approved.
2/4/2016	Gary Poe	Kingsport, TN	I am particularly pleased that the new healthcare entity will be a merger of two non-profits who have outstanding records of providing both excellent healthcare and service to the community. It is of huge benefit to the community that the management will continue to be local and operating surpluses will continue to accrue to the benefit of the local community. I like that the pre-sub. report defines the commitments being made.
2/4/2016	Lisa Buchanan	Kingsport, TN	The merger of Wellmont and Mountain States health systems will be positive for individuals and families in our region. I look forward to greater continuity of care and better access to specialists. As a former social worker, I am particularly encouraged by the awareness of and plans to address the unique health needs of our area – substance abuse and mental health, neonatal abstinence syndrome, childhood obesity, and other poverty-related health problems.
2/5/2016	Mike Beery	Johnson City, TN	I am supportive of this merger for several specifics reasons addressed below.

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	**Name**	**City**	**Comment**
			There is a significant need in our region to eliminate the duplication of services that has led to an inefficient business model. There is a significant need in the region to improve the overall comprehensive health of the citizens with a focus on prevention. There is a significant need to have a patient record system that is available for any review by any medical staff….not just the primary physican in one location. This pre-submission includes a strong set of metrics (checks and balances) that will track the improved performance of cost, quality and services.
2/9/16	Fielding Rolston		Congratulations on the development of a plan that effectively addresses the health issues of our region. This plan will reduce costs, improve quality, and enhance the value of ETSU Medical School.
2/11/16	Gary Mabrey	Johnson City, TN	This report illustrates the basis for the merger and the benefits to the region. Our citizens will accrue the benefits with improved healthcare. We will address prevention and wellness in ways that will enhance our quality of life. Recruitment of needed specialties will occur as well as vital research that will enhance the assets of ETSU Academic Health Science Center, Milligan Collefe and other higher ed institutions. This will be great for business retention and recruitment. We applaud the leadership of these two fine institutions and lol forward to the merger.
2/11/16	Miles Burdine	Kingsport, TN	So many positive reasons that the merging of Wellmont and Mountain States needs to happen. Among them: Significant cost savings, less duplication, more research opportunities, access to services that have typically not been available here, significant branding opportunities, potential for capital investment and job creation, etc. Our communities appreciate and respect the transparency that has been evident throughout the process.
2/11/16	Nicole Austin	Kingsport, TN	It is truly encouraging to see both systems coming together to make healthcare even better in our region. As a representative of the business community and as a patient I am looking forward to seeing all the positive outcomes this merger will create. Thank you to both systems for leading and for all the hard work that has gone in to making this happen. Nicole
2/12/16	Charlie	Kingsport,	Thanks for all the work you're doing. This report is

Table 15. WEBSITE COMMENTS & QUESTIONS SUBMITTED BETWEEN JANUARY 7, 2016 AND FEBRUARY 12, 2016.			
Date	**Name**	**City**	**Comment**
	Glass	TN	impressive and I am encouraged by the progress and commitment to improving community health. I particularly am looking forward to your commitment of $75million toward working with community agencies and existing resources to impact population health in our region. There is a tremendous opportunity for the new health system to "shepherd" existing community resources toward some key common goals. We don't need to reinvent the wheel, and this report indicates you are in agreement with that. Thank you!

8. COMMUNITY LETTERS OF SUPPORT

Officials in both Virginia and Tennessee received 60 letters from employers, community organizations, and other leaders from across the region served by the Parties who fully support the merger and the Parties' vision for improving the health of the region. Copies of these letters were provided to Wellmont and Mountain States, and a list of them is below.

Copies of all of the letters listed below are included as part of **Attachment G**.

Table 16. Letters of Support submitted between July 7, 2015 and Tuesday, February 9, 2016.

Table 16. LETTERS OF SUPPORT SUBMITTED BETWEEN JULY 7, 2015 AND FEBRUARY 8, 2016			
Organization	**Addressed To**	**Date**	**Notes**
Dr. Weberling & Associates	Secretary William Hazel	N/A	Attached
Lottie Fields Ryan	Commissioner John Dreyzehner	N/A	Attached
UBS	Commissioner John Dreyzehner	7/7/15	Attached
Ideal Rental Properties	Commissioner John Dreyzehner	7/8/15	Attached
Judy Seaton	Commissioner John Dreyzehner	7/8/15	Attached
S. H. Anderson, Jr.	Commissioner John Dreyzehner	7/13/15	Attached
Southwest Virginia Higher Education Center	Secretary William Hazel	7/15/15	Attached
Leonard Companies, Ltd.	Secretary William Hazel	7/20/15	Attached
South-West Insurance Agency	Secretary William Hazel	7/20/15	Attached
Ball Construction Co., Inc.	Secretary William Hazel	7/21/15	Attached
Calvin & Leslie Clifton	Commissioner John Dreyzehner	7/21/15	Attached
Cary Street Partners, LLC	Attorney General Mark Herring	7/21/15	Attached
Cary Street Partners, LLC	Secretary William Hazel	7/21/15	Attached
Miners Exchange Bank	Secretary William Hazel	7/21/15	Attached
Colgard Outdoor Sports	Secretary William Hazel	7/23/15	Attached
Damascus	Secretary William Hazel	7/23/15	Attached
Friendship Enterprises	Elliott Moore	7/24/15	Attached
Friendship Enterprises	Commissioner John Dreyzehner	7/24/15	Attached
Norton Redevelopment & Housing Authority	Secretary William Hazel	7/24/15	Attached
Bank of Tennessee	Commissioner John Dreyzehner	7/27/15	Attached
Bank of Tennessee	Secretary William Hazel	7/27/15	Attached
Bank of Tennessee	Secretary William Hazel	7/27/15	Attached
Charles E. Good	Commissioner John Dreyzehner	7/27/15	Attached
Farm Credit Country Mortgages	Secretary William Hazel	7/27/15	Attached
C. Thomas Davenport, Jr.	Commissioner John Dreyzehner	7/28/15	Attached
Strongwell	Commissioner John Dreyzehner	7/28/15	Attached
VHCC	Secretary William Hazel	7/28/15	Attached
JAS General Contractor	Commissioner John Dreyzehner	7/29/15	Attached

Table 16. LETTERS OF SUPPORT SUBMITTED BETWEEN JULY 7, 2015 AND FEBRUARY 8, 2016			
Organization	**Addressed To**	**Date**	**Notes**
Strongwell	Secretary William Hazel	7/29/15	Attached
Citizens Bank	Commissioner John Dreyzehner	7/31/15	Attached
Town of Clintwood	Secretary William Hazel	8/3/15	Attached
First Bank & Trust Company	Secretary William Hazel	8/7/15	Attached
Dillon Company	Secretary William Hazel	8/11/15	Attached
GRC Construction	Commissioner John Dreyzehner	8/11/15	Attached
HealthSouth	Commissioner John Dreyzehner	8/11/15	Attached
Washington County Chamber of Commerce	Secretary William Hazel	8/23/15	Attached
Appalachian Power	Commissioner John Dreyzehner	8/24/15	Attached
YMCA	Commissioner John Dreyzehner	8/28/15	Attached
First Baptist Church	Commissioner John Dreyzehner	9/2/15	Attached
Healing Hands Health Center	Commissioner John Dreyzehner	9/28/15	Attached
Healing Hands Health Center	Secretary William Hazel	9/28/15	Attached
Dickenson County Chamber of Commerce	Secretary William Hazel	10/13/15	Attached
Chris Mullins Co, LLC	Commissioner John Dreyzehner	10/15/15	Attached
Mike McIntire	Commissioner John Dreyzehner	11/2/15	Attached
Mike McIntire	Attorney General Herbert Slatery	11/2/15	Attached
Eastman Credit Union	Commissioner John Dreyzehner	11/3/15	Attached
Rebecca C. Coleman	Secretary William Hazel	11/11/15	Attached
The United Company	Commissioner John Dreyzehner	11/11/15	Attached
The United Company	Secretary William Hazel	11/11/15	Attached
Jeanette D. Blazier, Former Mayor	Commissioner John Dreyzehner	11/12/15	Attached
Bank of Tennessee	Commissioner John Dreyzehner	11/18/15	Attached
Bill Gatton Chevrolet	Commissioner John Dreyzehner	11/18/15	Attached
Bill Gatton Chevrolet	Secretary William Hazel	11/18/15	Attached
Northeast State	Commissioner John Dreyzehner	11/24/15	Attached
John M. Vann	Commissioner John Dreyzehner	11/30/15	Attached

See ATTACHMENT G: Community Letters of Support

Record of Community Stakeholder and Consumer Views

of the Proposed Cooperative Agreement

ATTACHMENT A

Better Together Press Releases

FOR IMMEDIATE RELEASE:

MEDIA CONTACTS:
Jim Wozniak, Wellmont
Jim.Wozniak@wellmont.org
(423) 408-7299

Teresa Hicks, MSHA
HicksTE@msha.com
(423) 943-6907

Media Advisory: Wellmont and Mountain States leaders invite members of the media to join us for a media briefing today at 2 p.m. in the Warriors Path Amphitheater in the Executive Conference Center at MeadowView Conference Resort & Convention Center. We invite set-up at 1:45 p.m.

WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE ANNOUNCE PLANS TO PURSUE AN INTEGRATED HEALTH SYSTEM

New organization would make health care more affordable, redirect resources toward improving health of region

KINGSPORT and JOHNSON CITY, Tenn. – (April 2, 2015) – Wellmont Health System and Mountain States Health Alliance have agreed to exclusively explore the creation of a new, integrated and locally governed health system designed to address the serious health issues affecting the region and to be among the best in the nation in terms of quality, affordability and patient satisfaction.

In a term sheet signed Wednesday, the boards of directors of both organizations agree to explore combining the assets and operations of Wellmont and Mountain States into a new health system. This decision follows more than a year of merger discussions, internal analysis within each system, thoughtful conversations in the community and unanimous votes by both boards to examine this option.

"We are excited about this proposed combination that will bring together the capabilities of both Wellmont and Mountain States, combined with a partnership in academics and with our states, to serve the region and result in unprecedented quality and value," said Roger Leonard, chair of Wellmont's board. "We are grateful to the thousands of community and business leaders, physicians, employees and patients who have shared their thoughts throughout this process. It was deliberative and methodical, which led us unanimously to the right conclusion."

"Our board is enthusiastic about this potential partnership," said Barbara Allen, chair of the board for Mountain States. "We and the leadership of Wellmont all care deeply about the region we serve. We share a passion for improving our region's health and our region's economy. We look forward to working closely with the state of Tennessee and the Commonwealth of Virginia, as well as with our payors, to focus on the real drivers of cost reduction and quality-enhancement."

A new board will be created, which will have equal representation from Wellmont and Mountain States, as well as two new independent, jointly appointed members. The board will also include a lead independent director who will be a Wellmont board appointee who will work with the board in coordination with the executive chairman. This is a best practice model frequently used by companies who have an executive chairman.

The president of East Tennessee State University will serve as an ex-officio nonvoting member of the board. The involvement of ETSU will focus on expanding opportunities to compete for research investment in our region, as well as enhancing physician and allied health training for the future.

This new board would direct the proposed health system, which would also have a new name. One leadership team, composed of current executives from both organizations, would lead the combined system. The CEOs of both organizations would share leadership responsibilities.

"Northeast Tennessee and Southwest Virginia disproportionately suffer from serious health issues – cardiovascular disease, diabetes, addiction and access to mental health services, to name a few – and they must be addressed," said Alan Levine, president and CEO of Mountain States, who would become executive chairman and president of the combined system. "The cost of this poor health is not sustainable. By integrating, we can refocus our efforts from being measured based on how many patients we can admit to the hospital and how many ways we can duplicate these efforts, to how we measurably improve the health of our region while eliminating unnecessary costs and making health care more affordable. The people of this region deserve nothing less. We intend to demonstrate the merger's substantial specific potential in these areas."

An integration council with executive and physician leaders from both systems will be formed to further develop plans for a combined system during the next several months. Those plans will be in the best interest of clinical quality and the patients served, will demonstrate shared values and will honor commitments to employees and physicians.

"Together, we'll work alongside our employed and independent physicians to shape the future of health care by modeling effective clinical collaboration, building new community health solutions and becoming a national model for rural health care delivery," said Bart Hove, president and CEO of Wellmont, who would be CEO of the new system. "As one system, our physicians would share best practices, collaborate to benchmark our outcomes against the nation's best and develop new high-level services closer to home."

The systems now enter a due diligence period and will work toward developing a definitive agreement. The definitive agreement will be followed by a process to obtain, among other regulatory requirements, Tennessee and Virginia approvals of the merger, which will likely take through the end of 2015.

In Tennessee, the organizations will pursue approval under the state's COPA (Certificate of Public Advantage) statute. A COPA authorizes the parties to merge and directs the state to actively supervise the new health system to ensure that it continues to benefit the community by providing health care that is affordable, accessible, cost-efficient and high in quality. In Virginia, the health systems will pursue a process similar to a COPA that is defined by a proposed statute that has been passed by the legislature and awaits the governor's signature.

During the next phases of due diligence, integration analysis, planning for potential integration and government approval, both Mountain States and Wellmont will continue "business as usual" as two separate and independent organizations.

For more information, please visit www.becomingbettertogether.org.

About Wellmont Health System

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About Mountain States Health Alliance

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WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE NAME MEMBERS OF INTEGRATION COUNCIL

As Wellmont Health System and Mountain States Health Alliance proceed with plans for integrating the two organizations, they have selected members of a committee that will help direct this multi-tiered process.

The two not-for-profit companies announced on Thursday, April 2, that they have agreed to explore the creation of a new, integrated and locally governed health system. The systems have now entered a due diligence period and are working to develop a definitive agreement.

This agreement will be followed by a process to obtain, among other regulatory requirements, Tennessee and Virginia approvals of the merger, which will likely take through the end of 2015.

One of the first elements of the process is the selection of an integration council. This group of executive and physician leaders is the working group charged with overseeing pre-merger planning. The integration council will have an equal number of representatives from Wellmont and Mountain States and make its recommendations to the joint board task force, which is the governing group that will consist of leaders from each health system.

The Wellmont council members are:

- Eric Deaton, executive vice president and chief operating officer
- Alice Pope, executive vice president and chief financial officer
- Todd Norris, senior vice president for system advancement
- Gary Miller, senior vice president of legal affairs and general counsel
- Dr. Dale Sargent, system medical director for hospitalist services and former chief medical officer

Wellmont still has one physician slot to fill.

The Mountain States council members are:

- Marvin Eichorn, executive vice president and chief operating officer
- Dr. Morris Seligman, executive vice president and chief medical officer
- Lynn Krutak, senior vice president and chief financial officer

- Tony Keck, senior vice president and chief development officer
- Tim Belisle, senior vice president and general counsel
- Dr. Sandra Brooks, a system board member and vice president of Watauga Pathology Associates

"We are excited to be taking the first steps in the integration planning process with our counterparts at Wellmont," said Alan Levine, Mountain States' president and CEO. "Both organizations have assembled a team of talented and knowledgeable leaders, and their focus is now on putting the pieces in place for a definitive agreement."

"These are outstanding members of our organizations, and they will play an important role in developing a plan for integration of the new health system that will further advance the quality of care in our region," said Bart Hove, Wellmont's president and CEO. "These are exciting times for Wellmont, but we still have much work to complete in the process of planning how the organizations will integrate, once we obtain all legal clearances. But we are pleased to be making tremendous progress as we move forward on this beneficial initiative."

Among other tasks, the council will conduct a cultural assessment and ensure a proper due diligence is conducted. The council will also coordinate the process for the attainment of the certificate of public advantage in Tennessee and similar administrative approval from Virginia.

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WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE NAME MEMBERS OF JOINT BOARD TASK FORCE

Task force to represent existing governing bodies as proposed merger process moves forward

KINGSPORT and JOHNSON CITY, Tenn. – (May 4, 2015) – Wellmont Health System and Mountain States Health Alliance leaders have appointed a joint board task force as work continues to explore the creation of a new, integrated and locally governed health system.

The joint board task force is a committee of the two boards acting as a liaison and providing information and guidance about developments in the transaction exploration process. Totaling 14 members, the task force is composed of an equal number of representatives appointed by the Mountain States and Wellmont boards. The members represent a cross section of regional and physician leadership from the community, incorporating those with experience in governance, administration, business and strategy – both in health care and in the business community.

The group is primarily responsible for providing a conduit to the existing boards of directors about the progress being made as the two systems undertake due diligence and transaction analysis and purse a potential definitive agreement.

Wellmont's joint board task force members are:

- **Dr. Nelson Gwaltney**, of Bristol, Tennessee, a member of the Wellmont board of directors, president of Highlands Physicians Inc. and a general surgeon on the medical staff of Bristol Regional Medical Center;
- **Bart Hove,** of Kingsport, Tennessee president and CEO of Wellmont Health System;
- **Roger Leonard**, of Bristol, Tennessee, chair of the Wellmont board of directors and a senior adviser to England & Company;
- **Roger K. Mowen Jr.**, of Kingsport, Tennessee, a member of the Wellmont board of directors and retired senior vice president of global developing businesses and corporate strategy for Eastman Chemical Company;
- **Dr. Doug Springer**, of Kingsport, Tennessee, a gastroenterologist on the medical staff of Holston Valley Medical Center, a member of the Wellmont board of directors and immediate past president of the Tennessee Medical Association;

- **Dr. David Thompson**, of Bristol, Tennessee, an internal medicine physician with Wellmont Medical Associates in Bristol, who also practices in Abingdon, Virginia, and is a Wellmont board member and chairman of the Wellmont Medical Associates board of directors; and
- **Keith Wilson**, of Kingsport, Tennessee, who owns a secondary residence and a farm in Scott County, Virginia, a member of the Wellmont board of directors, publisher of the Kingsport Times-News and president of Northeast Tennessee Media Group.

Mountain States' joint board task force members are:

- **Barbara Allen**, of Johnson City, Tennessee, chair of the Mountain States board of directors and general manager of Stowaway Storage, a family-owned business in Johnson City;
- **Bob Feathers**, of Kingsport, Tennessee, a member of the Mountain States board of directors and president and CEO of Workspace Interiors, Inc.;
- **Alan Levine**, of Johnson City, Tennessee, president and CEO of Mountain States Health Alliance;
- **Dr. David May**, of Elizabethton, Tennessee, a member of the Mountain States board of directors and immediate past president of the medical staff at Sycamore Shoals Hospital;
- **Dr. Rick Moulton**, of Johnson City, Tennessee, medical director of clinical integration for State of Franklin Healthcare Associates and chairman of the SoFHA patient centered medical home committee;
- **Gary Peacock**, of Marion, Virginia, a member of the Mountain States board of directors, former chair of the Smyth County Community Hospital board of directors, and retired senior vice president of Royal Mouldings; and
- **Clem Wilkes, Jr.** of Johnson City, Tennessee, a member of the Mountain States board of directors and co-manager of Citizens Investment Services, a subsidiary of Citizens Bank Tri-Cities.

From now until the potential transaction closes, Wellmont and Mountain States will remain separate and independent organizations, conducting "business as usual." Their respective boards of directors continue to govern the operations of each health system separately and independently, until all regulatory approvals have been granted and the merger is complete.

A board for the new proposed system will be appointed prior to the completion of the merger.

"During this current phase, our primary focus is on due diligence, confirming the transaction's potential for substantial cost-savings, quality-of-care enhancements and other community benefits, pursuing a definitive agreement and laying the groundwork for creating the new system," said Bart Hove, president and CEO of Wellmont. "The joint board task force and integration council will focus on preparing for what we expect will be a highly successful integration. Once the new health system is formed post-closing, a new board will take over the responsibility for governance and overseeing the implementation of an exciting vision for the future of health care in this region, which will be crafted with significant input from our physicians, team members and the community."

"Some of the tasks before us include due diligence, a more detailed analysis and quantification of the transaction's substantial benefits for the community, culture and governance audits and preparations for crafting our application for a certificate of public advantage in Tennessee and a similar approval in Virginia," said Alan Levine, president and CEO of Mountain States. "We view the certificate of public advantage and the regulatory process as an important memorialization of our commitment to the people of this region, and

we're excited to begin working toward that goal. We are definitely committed to seeking public input, and this is the next order of business."

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WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE TO SEEK INPUT ON KEY HEALTH ISSUES, CALL FOR PUBLIC PARTICIPATION

Work groups to hold public meetings, provide input to assist health systems in development of long-term plan for improving the health of the region

KINGSPORT and JOHNSON CITY, Tenn. – (June 10, 2015) – Mountain States Health Alliance and Wellmont Health System officials are creating four community work groups designed to provide public input as the two organizations continue to explore the creation of a new, integrated and locally governed entity.

Through the website, BecomingBetterTogether.org, the health systems are requesting participation in the work groups from the community as well as subject matter experts such as nurses and other health professionals, doctors, public health officials and community advocates.

"Our organizations have committed to an open process as we consider the creation of a truly new health improvement organization for our region," said Bart Hove, president and CEO of Wellmont. "These work groups provide a great opportunity for interested organizations and individuals to participate with us as we develop our strategies for improving the health of our area."

The work groups will provide input in solving some of the region's most challenging health issues: Mental Health and Addiction, Healthy Children and Families, Research and Academics, and Population Health and Healthy Communities. The work groups' findings will be used by East Tennessee State University as part of a deep-dive health needs assessment that will be conducted after the proposed merger between Mountain States and Wellmont is complete.

That assessment will provide a road map for the proposed new health system as it lays out a 10-year plan to improve community health. The work group meetings are designed to focus specifically on health improvement and are separate from public meetings that will be held in Tennessee and Virginia as part of the state approval process for the proposed merger.

The work groups are divided into four key areas of opportunity:

Mental Health and Addiction – This group will evaluate the inventory of mental health and addiction services for adults and children in the area. Among other tasks, this group will assess gaps in access points, review strategies to prevent drug and alcohol use among youth and explore structures to better integrate primary care in coordinating mental health and addiction treatment. The proposed new system will be dedicated to partnering with the medical and social service community to combat addiction and help the next generation achieve its potential.

Healthy Children and Families – This group will identify the most prominent physical, behavioral and social health problems among children in the region and explore their causes. The group will examine access points for children and evaluate strategies that have worked well in other communities. In addition, this group will identify gaps in educational achievement, particularly literacy and basic skills, and take inventory of community services available for children with special needs and developmental or physical disabilities.

Research and Academics – This group will identify specific ways the proposed new organization can work with ETSU and other academic institutions to substantially enhance the health and economic development of the region by expanding research, training, and the application of public health policy to improve health.

Population Health and Healthy Communities – Incorporating input from the other work groups, this group will identify the top health problems in the region and their clinical and social causes and will inventory current and past efforts to address these problems. The group will also identify successful community governance structures used locally or nationally (such as accountable care communities) that leverage schools, businesses, civic and faith groups, health care providers and government to improve health and wellness.

"Reducing untimely deaths and suffering from heart disease, diabetes, addiction and other chronic diseases through better screening, prevention and treatment is critical to improving the overall health of our region," said Alan Levine, president and CEO of Mountain States. "But a healthy community is much more than the absence of disease – it means educated, safe and confident young people and adults able to pursue their ambitions and contribute to our community's well-being."

The work groups will begin meeting in July and will continue through the end of the year. Each group will hold public meetings, which will rotate throughout Northeast Tennessee and Southwest Virginia, to seek input from members of the community as well as organizations and experts interested in these areas. Each work group will be led by a subject matter expert and will include members from throughout the region who represent a broad variety of experience and perspectives. Work groups will be staffed by members of Mountain States and Wellmont along with master's and doctoral level students from ETSU.

Work groups will provide regular updates as well as final findings to the Integration Council, a group of executive and physician leaders from both systems who are overseeing the analysis and making preparations for the integration of the proposed combined system.

As these groups form, due diligence research, led by the Integration Council and the Joint Board Task Force, continues between Wellmont and Mountain States to establish the proposed new system. The next step is approval of a definitive agreement by both organizations' boards of directors, after which the systems will enter a government approval phase that will likely take through the end of 2015.

During the due diligence and government approval phases and until the closing, Mountain States and Wellmont will continue "business as usual" as two separate and independent organizations.

To learn more about the work groups and how to participate, visit BecomingBetterTogether.org.

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WELLMONT, MOUNTAIN STATES ANNOUNCE CHAIRS, MEETING DATES FOR COMMUNITY HEALTH WORK GROUPS

Community round table meetings to solicit public input on important health issues in the region

KINGSPORT and JOHNSON CITY, Tenn. – (August 5, 2015) – Mountain States Health Alliance and Wellmont Health System have scheduled a series of community meetings to solicit input as the organizations work together to solve some of the region's most challenging health issues, as part of the proposed merger.

The meetings are part of the health systems' previously announced work groups initiative that will focus on four key areas: Mental Health & Addiction; Healthy Children & Families; Population Health & Healthy Communities; and Research & Academics. More than 100 community members responded to the call for participation through the BecomingBetterTogether.org website, and dozens more were recommended by key stakeholders as valuable participants in the process.

"We are pleased with the sincere interest throughout the region, and we are grateful for these distinguished members of the community who have agreed to lead these work groups," said Alan Levine, president and CEO of Mountain States.

Eight community leaders have agreed to serve as chairpersons leading the four work groups:

- Mental Health & Addiction: Dr. Teresa Kidd, president and CEO of Frontier Health, and Eric Greene, senior vice president of Virginia services for Frontier Health;
- Healthy Children & Families: Dr. David Wood, chair of the department of pediatrics at East Tennessee State University and chief medical officer of Niswonger Children's Hospital, and Travis Staton, CEO of United Way of Southwest Virginia;
- Population Health & Healthy Communities: Dr. Randy Wykoff, dean of ETSU's College of Public Health, and Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City;
- Research & Academics: Dr. Wilsie Bishop, vice president for health affairs and chief operating officer of East Tennessee State University, and Jake Schrum, president of Emory & Henry.

"This is a tremendously talented group of individuals with expertise that spans multiple disciplines and geographic regions," said Bart Hove, president and CEO of Wellmont. "We are honored to

have them on board in this process and will benefit from their broad knowledge and community involvement."

The public has a critical role to play in this process. The College of Public Health at East Tennessee State University (ETSU) will coordinate a series of community round table meetings designed to give residents an opportunity to provide input on the most pressing health concerns they see in their communities. The round table meetings will be held in various locations throughout the region, with a goal of soliciting input from a broad audience, including rural areas.

In addition, Wellmont and Mountain States leaders are partnering with ETSU and the work group chairs to assemble steering committees for each focus area. The steering committees will hold separate meetings to examine top health issues and also review presentations from health experts and community members. Wellmont and Mountain States officials are working with the eight chairpersons to finalize membership for the steering committees. Once complete, the members' names will be posted on BecomingBetterTogether.org. Both the community round table meetings and the work group steering committee meetings are open to the public.

The first two community round table meetings will take place Aug. 13 and Aug. 20.

- Thursday, August 13, 5:30 – 7:30 p.m.

Tennessee College of Applied Technology, 425 TN-91, Elizabethton, Tenn.

- Thursday, August 20, 5:30 – 7:30 p.m.

Southwest Virginia Higher Education Center, One Partnership Circle, Abingdon, Va.

Community members who wish to attend a meeting are asked to RSVP online at BecomingBetterTogether.org. Additional meetings will be scheduled in the coming weeks; for the most up-to-date schedule, visit BecomingBetterTogether.org.

The public meetings will be facilitated by ETSU's College of Public Health and will feature a "world café" style discussion with participants circulating through a series of small group tables to exchange thoughts and ideas. ETSU staff will record the information presented during the meetings and compile findings from the meetings into a comprehensive report that will be used by the proposed new health system.

"Here in our region, there is a cycle of poor health that we see being passed from one generation to the next," said Dr. Randy Wykoff, dean of the ETSU College of Public Health. "Our goal is to gather information that will allow the proposed new health improvement organization to use its resources to help break that intergenerational cycle of poor health. The proposed merger between Mountain States and Wellmont affords our region the opportunity to impact health in ways that weren't possible in the past, so this is a very exciting opportunity from a public health perspective."

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WELLMONT, MOUNTAIN STATES FILE LETTERS OF INTENT TO BEGIN REGULATORY APPROVAL PROCESS IN TENNESSEE AND VIRGINIA

Actions mark next steps in the process to pursue state approval for the proposed merger

KINGSPORT and JOHNSON CITY, Tenn. (September 16, 2015) – Wellmont Health System and Mountain States Health Alliance have filed a letter of intent (LOI) with the Tennessee Department of Health, indicating the organizations will submit an application for a Certificate of Public Advantage (COPA) this fall. The two organizations have submitted a similar letter of intent with the Southwest Virginia Health Authority, signaling their intent to request approval by the commonwealth of the anticipated cooperative agreement between the two systems.

These actions mark the next steps in the regulatory processes the organizations are following as they explore the creation of a new, integrated and locally governed health system designed to be among the best in the nation and address the serious health issues that affect our region.

"The underlying purpose for the proposed merger is to reduce the growth in health care costs, improve the health of our region and invest in the growth of our economy," said Alan Levine, president and CEO of Mountain States. "The job creators and employers in our region support this model because they know, as we do, that a locally governed system, under the enforceable agreement of a COPA, will be the best alternative to the widespread consolidation wave happening to hospitals and insurance companies."

Next, the two organizations will finalize a definitive agreement, which is another formal step in the process to solidify the proposed partnership. The date for expected completion of the merger has not been set but will not occur before state approval has been granted.

A COPA in Tennessee and the cooperative agreement approval process in Virginia will allow Wellmont and Mountain States to merge, with the states actively supervising the proposed new health system to ensure it complies with the provisions of the COPA intended to contain costs and sustain high quality, affordable care.

"COPA regulation with active supervision by the states is a proven and effective tool to protect consumers, as opposed to traditional hospital mergers occurring all across the country that do not include state involvement and ongoing oversight," said Bart Hove, president and CEO of Wellmont. "With this proposed merger, our patients and our region will have access to more choices and health care options than they do today – and more than with any other solution."

"In fact, other paths we explored could have led to loss of local control and jobs to new owners outside the region, as well as increased costs. We believe the proposed merger is the best approach for our community, and we greatly appreciate the hard work of officials in both states to provide a path for our vision to become a reality."

Tennessee's Department of Health recently released interim regulations governing COPAs in Tennessee, and Virginia's Department of Health is finalizing rules to oversee similar cooperative agreements in that state. The rules provide a process and framework for state officials to follow in receiving and reviewing applications for a COPA/cooperative agreement and then actively supervising these agreements if approved.

In Virginia, a group of 25 physicians, community members and business leaders recently attended a meeting hosted by the Virginia Department of Health to express their opinions on the proposed regulations as well as their support for the proposed merger.

"We've been truly humbled by the outpouring of support we've received from business leaders, physicians and the community over the past few months," Hove said. "It's great to see that so many people in our region share our excitement about what we're creating."

"As we've said from the beginning, we are committed to being transparent about the efforts underway to pursue approval for our proposed merger," Levine said. "While filing the letters of intent with Tennessee and Virginia are important next steps, they are simply two of many that will occur in the next few months. There is still a lot of work ahead. But, we grow more confident every day in our ability to work together to create a bright future for health care in our region."

View copies of the Tennessee and Virginia letters of intent.

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Media Advisory: We invite members of the media to join us for a media briefing today at 2 p.m. at the Bristol Chamber of Commerce. Set up is available at 1:45 p.m. A conference call line is also available at 2 p.m. by calling 855-749-4750, with the access code of 28068129.

WELLMONT, MOUNTAIN STATES SHARE PUBLIC REPORT OUTLINING FUTURE PLANS TO IMPROVE HEALTH IN REGION

Report reflects extensive community input, describes commitments in six key areas

KINGSPORT and JOHNSON CITY, Tenn. (January 7, 2016) – Mountain States Health Alliance and Wellmont Health System today released a public report outlining a series of binding commitments the proposed new organization will make about how it will operate and uniquely serve the community together. The report describes commitments in six key areas to improve health in the region.

The commitments include: improving community health, enhancing health care services, expanding health care choices and access to care, enhancing health care value, investing in health research and education, and attracting and retaining a strong workforce.

Unlike traditional mergers and consolidation, the proposed organization also commits to reduce the pace of growth in health care costs to below the national average by placing limits on negotiated rates with insurers.

"Our management teams working together continue to make very careful and deliberate progress with the proposed merger and are excited to take this next step by sharing our transformational vision, which has drawn widespread support from community, business and governmental leaders throughout our region and respective states," said Roger Leonard, chair of Wellmont's board of directors. "We look forward to working with officials in Tennessee and Virginia as they evaluate the report and upcoming filings so this process can reach a successful conclusion. We appreciate their engagement and willingness to provide the framework that will produce an innovative, nationally recognized model that will promote improved health and quality of life for our families, friends and neighbors."

The pre-submission report, required by the regulatory approval processes in Tennessee and Virginia, precedes the filing of applications for approval of the proposed merger in both states.

"The path we are pursuing is an innovative model unlike the traditional mergers that are common among hospitals and providers today," said Barbara Allen, chair of the Mountain States board of directors. "We believe our proposed alternative is better. It is the only model that maintains local

governance, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region and invests those dollars in the improved health of our region while preserving local jobs."

Specifically, Wellmont and Mountain States are committing to a series of transformational investments, made possible through financial efficiencies that will be achieved with the proposed merger, in the following ways over the next 10 years:

- **At least $75 million** to invest in population health improvements to meet the unique health needs of our region through a 10-year plan to be developed with the community and the public health resources at ETSU;
- **At least $140 million** to expand community-based mental health services, residential and outpatient addiction recovery programs, and tobacco and substance abuse prevention programs as well as to further support children's and rural health services;
- **At least $85 million** to develop and grow academic and research opportunities, support post-graduate health care training, and strengthen the pipeline and preparation of health professionals in the region; and
- **Up to $150 million** to implement a common information technology platform to support the regional exchange of health information, connect our hospitals, physicians and other caregivers, and allow the combined system to offer higher quality, more convenient and more cost-effective care for patients.

The commitments outlined in the report were developed after careful review of a variety of research and data, including the state health plans from Tennessee and Virginia, the Southwest Virginia Health Authority's Blueprint for Health Improvement and Health-Enabled Prosperity, the two organizations' initial due diligence, input from community meetings, local health data and statistics, projected health needs, existing services, financial data, and more.

"These commitments reflect months of extensive conversations with stakeholders across our region," said Alan Levine, president and CEO of Mountain States. "The transformational investments outlined in this report would not be possible without the savings realized by combining our two organizations."

Wellmont and Mountain States anticipate filing the applications for a Certificate of Public Advantage (COPA) with the Tennessee Department of Health and a cooperative agreement with the Southwest Virginia Health Authority in late January after a period of public comment on the pre-submission report. The applications will initiate the state review process, which is expected to extend into the late summer of 2016.

Should Tennessee and Virginia approve the applications and the merger becomes final, the state and commonwealth will supervise the new organization and enforce the commitments to ensure the public benefits.

"Our health systems are fortunate to have highly regarded physicians and other dedicated professionals who have enabled us to serve the region with distinction for decades," said Bart Hove, Wellmont's president and CEO. "Because of the investments we are committing to make, new opportunities will be created that will provide a brighter future with more opportunities for all because we will be a stronger organization together than would otherwise be the case."

The community is encouraged to review the report and comment on its contents at www.BecomingBetterTogether.org. The website also provides further information about the proposed merger process, including frequently asked questions, news and updates and more. A summary of the commitments outlined in the pre-submission report is attached to this release.

About Wellmont Health System

Wellmont Health System is a leading provider of health care services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive health care, wellness, and long-term care services across the region. Wellmont facilities include Holston Valley Medical Center in Kingsport, Tenn.; Bristol Regional Medical Center in Bristol, Tenn.; Mountain View Regional Medical Center in Norton, Va.; Lonesome Pine Hospital in Big Stone Gap, Va.; Hawkins County Memorial Hospital in Rogersville, Tenn.; and Hancock County Hospital in Sneedville, Tenn. For more information about Wellmont, please visit www.wellmont.org.

About Mountain States Health Alliance

Since 1998, Mountain States Health Alliance has been bringing the nation's best health care close to home to serve the residents of Northeast Tennessee, Southwest Virginia, Southeastern Kentucky and Western North Carolina. This not-for-profit health care organization based in Johnson City, Tenn., operates family of 13 hospitals serving a 29-county region. Mountain States offers a large tertiary hospital with level 1 trauma center, a dedicated children's hospital, several community hospitals, two critical access hospitals, a behavioral health hospital, two long-term care facilities, home care and hospice services, retail pharmacies, a comprehensive medical management corporation, and the region's only provider-owned health insurance company. The team members, physicians and volunteers who make up Mountain States Health Alliance are committed to caring for you and earning your trust. For more information, visit www.mountainstateshealth.com.

###

Record of Community Stakeholder and Consumer Views

of the Proposed Cooperative Agreement

ATTACHMENT B

Better Together Newsletters

Better Together

Wellmont Health System | Mountain States Health Alliance

Answering Your Questions

Recently, Wellmont Health System and Mountain States Health Alliance announced historic plans to explore the creation of a new, integrated and locally governed health system. Since that time, we have been overwhelmed by the terrific support and interest in what we are pursuing together.

We have also received a number of important questions asking why this is happening and what it means for our hospitals, physicians, team members and communities.

We are committed to answering as many of those questions as we can and to being as transparent as possible as our organizations pursue the work ahead. That's why we have created a couple of sources to accomplish that:

1. **The Better Together newsletter** – This newsletter will be sent out periodically to physicians and team members at both organizations, along with others in our community who sign up. It will have the latest information, address questions, and feature voices from the region. If you have ideas to make it better, let us know. People who are interested in receiving the newsletter can sign up at BecomingBetterTogether.org.

2. **BecomingBetterTogether.org** – We recently launched a website solely dedicated to providing the public with information about our shared vision to address the health issues that affect our region. There, we will provide updates about our efforts to unite our organizations. We encourage you to visit this site to learn more, submit questions, and stay

up-to-date with the latest information – for example, we recently announced the members of our Integration Council, which is charged with overseeing planning for the proposed merger.

Wellmont and Mountain States are committed to this process of exploration into creating a new, integrated system that will help make our region healthier while controlling costs and making healthcare more affordable.

Thank you for your interest and support. Many of you have taken the time to share your thoughts and ask important questions – it's clear that you care about the future of healthcare in our region just as much as we do.

Our Vision

To learn more about our shared vision for the future, view this new video below featuring Bart Hove, president and CEO of Wellmont, and Alan Levine, president and CEO of Mountain States.

Questions of the Week

In each newsletter, we will answer a couple of the hottest questions. For more answers, please go to our website, which will be updated frequently.

"Will the community be able to provide input regarding the new name of the future organization?"

Yes! As we explore creating a new, locally governed health system, we want to be sure the community – along with our own team members and physicians – has input in shaping it. We are not quite ready to begin the process of naming or branding, but stay tuned for how to chime in.

"How will employee benefits be impacted (retirement, health insurance, PTO, pension plan, etc.)?"

We understand how important these types of questions are. Today, we are still very early in exploring the specifics of what our future organization will look like.

What we can tell you today is that we would aspire to be one of the best healthcare employers in the country. Together, we would nurture a culture that promotes employee satisfaction and opportunity for professional growth. We promise to share more information when we are able.

"Won't we lose competition by combining Mountain States and Wellmont?"

Actually, with this merger, our patients and our region will have access to more choices and healthcare options than they do today. By combining our resources, we can draw more specialists and add new services for which people now have to drive hours to find. In addition, this potential new organization would involve the institution of a Certificate of Public Advantage or COPA, which establishes enforceable commitments to guard against effects from any loss of competition. A COPA will mean that the health system must meet commitments in driving down unnecessary costs, keeping care affordable, improving quality of care, enhancing access and benefiting the communities we serve. Learn more about the COPA process here.

Have a question? Submit it by clicking here, or to this email address:

info@becomingbettertogether.com.

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Better Together

Wellmont Health System | Mountain States Health Alliance

Thank You

Welcome to the second edition of the Better Together newsletter. We received great feedback on our first edition, which can be read here. We'll continue to provide regular updates on our process through this newsletter, our website – BecomingBetterTogether.org – and in other ways. Many of you have also visited our Q&A page to read the latest questions and answers or to ask your own question. We hope you'll continue to do so moving forward.

News and Updates

Our process to explore a potential merger is on track, and we want you to be the first to know an important update. When we made our announcement last month, we shared that a Joint Board Task Force would be created to act as a governing body of the process as we conduct due diligence, move toward a definitive agreement, and then move toward seeking regulatory approvals for the potential integration of our two organizations. This task force will be composed of members appointed by the current boards of Wellmont and Mountain States, as well as the CEOs of the two systems. Today, we're excited to announce the following members of the task force.

From Wellmont:

- **Dr. Nelson Gwaltney**, of Bristol, Tennessee, a member of the Wellmont board of directors, president of Highlands Physicians Inc. and a general surgeon on the medical staff of Bristol Regional Medical Center

- **Bart Hove**, of Kingsport, Tennessee president and CEO of Wellmont Health System

- **Roger Leonard**, of Bristol, Tennessee, chair of the Wellmont board of directors and a senior adviser to England & Company

- **Roger K. Mowen Jr.**, of Kingsport, Tennessee, a member of the Wellmont board of directors and retired senior vice president of global developing businesses and corporate strategy for Eastman Chemical Company

- **Dr. Doug Springer**, of Kingsport, Tennessee, a gastroenterologist on the medical staff of Holston Valley Medical Center, a member of the Wellmont board of directors and immediate past president of the Tennessee Medical Association

- **Dr. David Thompson**, of Bristol, Tennessee, an internal medicine physician with Wellmont Medical Associates in Bristol, who also practices in Abingdon, Virginia, and is a Wellmont board member and chairman of the Wellmont Medical Associates board of directors

- **Keith Wilson**, of Kingsport, Tennessee, who owns a secondary residence and a farm in Scott County, Virginia, a member of the Wellmont board of directors, publisher of the Kingsport Times-News and president of Northeast Tennessee Media Group

From Mountain States:

- **Barbara Allen**, of Johnson City, Tennessee, chair of the Mountain States board of directors and general manager of Stowaway Storage, a family-owned business in Johnson City

- **Bob Feathers**, of Kingsport, Tennessee, a member of the Mountain States board of directors and president and CEO of Workspace Interiors, Inc.

- **Alan Levine**, of Johnson City, Tennessee, president and CEO of

Mountain States Health Alliance

- **Dr. David May**, of Elizabethton, Tennessee, a member of the Mountain States board of directors and immediate past president of the medical staff at Sycamore Shoals Hospital

- **Dr. Rick Moulton**, of Johnson City, Tennessee, medical director of clinical integration for State of Franklin Healthcare Associates and chairman of the SoFHA patient centered medical home committee

- **Gary Peacock**, of Marion, Virginia, a member of the Mountain States board of directors, former chair of the Smyth County Community Hospital board of directors, and retired senior vice president of Royal Mouldings

- **Clem Wilkes, Jr.** of Johnson City, Tennessee, a member of the Mountain States board of directors and co-manager of Citizens Investment Services, a subsidiary of Citizens Bank Tri-Cities

Learn more about the Joint Board Task Force »

The Integration Council, which was named last month, has begun its work and will make recommendations for consideration by leadership and the Joint Board Task Force. For reference again, below are the members of the Integration Council.

From Wellmont:

- **Eric Deaton**, executive vice president and chief operating officer

- **Alice Pope**, executive vice president and chief financial officer

- **Todd Norris**, senior vice president for system advancement

- **Gary Miller**, senior vice president of legal affairs and general counsel

- **Dr. Dale Sargent**, system medical director for hospitalist services and

former chief medical officer

- **Dr. Bob Funke**, a member of Holston Valley Medical Center's Physician Clinical Council and former hospital board of directors member

From Mountain States:

- **Marvin Eichorn**, executive vice president and chief operating officer
- **Dr. Morris Seligman**, executive vice president and chief medical officer
- **Lynn Krutak**, senior vice president and chief financial officer
- **Tony Keck**, senior vice president and chief development officer
- **Tim Belisle**, senior vice president and general counsel
- **Dr. Sandra Brooks**, a system board member and vice president of Watauga Pathology Associates

In The News

In case you missed it, here are several recent news articles that may be of interest to you:

- MSHA, Wellmont officials answer viewer questions about merger
- Graduating nurses see opportunity in Tri-Cities health care future
- MSHA/Wellmont merger has support of TN's largest physicians organization
- Merger will impact ETSU

Thanks to Eastman Chemical Company and the president of District 5 of the Tennessee Nurses Association (which represents our region) for their positive comments and support of our process and vision.

"Eastman supports the decision to unify the systems in an effort to improve the quality and affordability of and access to health care in the region."

CeeGee McCord, Eastman Chemical Company; Source: Kingsport Times-News

"The Tennessee Nurses Association embraces the decision as one that will improve the quality of health care in our region, control spiraling costs, and better address the chronic health care issues facing this state."

Teresa A. Martin, MSN, FNP-BC, District President, on behalf of District 5, Tennessee Nurses Association; Source: WCYB

Questions of the Week

In each newsletter, we will answer a couple of the hottest questions. For more answers, please go to our website, which will be updated frequently.

"Are there plans to close one of the two hospitals in Norton, Virginia?"
A: There are no plans to close any hospitals. The services and programs offered by both organizations through our hospitals and other locations are always evolving in ways that reflect the input of our physicians and the needs of our patients. Long-term, the new organization will conduct a comprehensive health needs assessment to identify opportunities for new community-based resources and possibilities that don't exist today for our employees and communities.

"How does this decision impact ETSU?"
A: We believe our proposed new organization would positively impact East Tennessee State University and other academic institutions, as it would allow us to further advance clinical education in the region and to be more

competitive in pursuing research dollars currently flowing elsewhere nationally. In fact, the president of ETSU will also serve as an ex-officio member of the new system's Board.

Both Mountain States and Wellmont have been forced to reduce residency positions in recent years. We believe this partnership can help reverse that trend. We would partner with ETSU and others to strengthen the pipeline of physicians and allied health professionals and to attract research jobs and investments in our region. In addition, ETSU would help to conduct a substantial comprehensive regional health needs assessment to address health gaps and disparities, which will help shape the future direction of the potential new system and establish its priorities.

"What EHR system will be used by the combined entity?"
A: That is a major decision that has both strategic and clinical implications, and no decisions like this would be made until after the transaction closes (expected no earlier than the end of 2015). We will include significant input from our physicians before making any major decisions that will impact clinical care. What we do know today is that our combined organization would have a single EHR platform to ensure our facilities and providers work as seamlessly as possible with each other. We promise to share more information as soon as it's available.

Have a question? Submit it by clicking here or to this email address: info@becomingbettertogether.org.

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Better Together

Wellmont Health System | Mountain States Health Alliance

News & Updates

Welcome to the third edition of the Better Together newsletter.

Wellmont Health System and Mountain States Health Alliance continue the work of exploring our proposed future organization. Here are several updates:

- **COPA legislation:** On May 18, Gov. Bill Haslam, R-Tenn., signed a bill amending the state of Tennessee's Certificate of Public Advantage (COPA) statute. We supported this legislation, and applaud the governor for signing it. This statute provides guidelines to ensure that mergers, like the one we are exploring, provide for high quality, cost effective health care. The COPA will represent an agreement between our new system and the state of Tennessee, and compliance with the content of the agreement will be actively supervised by the state.

- **Nurse involvement in our planning efforts:** We've received several thoughtful questions through the Better Together website regarding the involvement of nurses in the planning efforts for the proposed new organization. See this week's "Questions of the Week" below. Our nurses are a vital part of both organizations and will be critically important in our proposed future organization as well. There will be a number of ways nurses and team members from both organizations will be heard through this process, and we'll keep you updated of these opportunities along the way.

- **iPad mini giveaways:** Congratulations to Beverly Stephens and Mike Housewright! Beverly won an iPad mini after entering the drawing at our Better Together booth during the Leadercast event in Kingsport, and Mike won an iPad mini after entering the drawing at the Tennessee Valley Corridor Summit at East Tennessee State University. Enjoy!

Community Support

We thank the Chambers of Commerce of Kingsport, Bristol and Johnson City / Jonesborough / Washington County for their recent letter of support for our proposed merger. The Chambers have invested a lot of time, on behalf of their hundreds of member businesses, learning about the possibilities for our region with the proposed merger. The support of the business community, which pays much of the cost of health care in our region, is critical to the success of the proposed new organization. The letter can be read here. Here is a brief excerpt:

"The Chambers of Commerce ... endorse the proposed merger of Wellmont Health System and Mountain States Health Alliance to an integrated single system. We believe this offers the best opportunity for the betterment of our region's healthcare."

The Chambers of Commerce of Kingsport, Bristol and Johnson City / Jonesborough / Washington County

Additionally, we want to thank Dr. Doug Springer of the Tennessee Medical Association for his statement of support:

"Combining strengths, assets and liabilities would enable these systems to focus more on quality, population health management, mental health programs and other services benefiting the entire region."

Douglas J. Springer, MD, immediate past president of the Tennessee Medical Association

Questions of the Week

In each newsletter, we will answer a couple of the hottest questions. For more answers, please go to our website , which will be updated frequently.

"Will nurses be involved in the planning efforts for the proposed new organization?"

A: Yes, absolutely – there will be a number of ways nurses from both Wellmont and Mountain States will be heard through this process. In fact, we won't be successful in accomplishing what we hope to do without the support and input of our nurses. As the Integration Council continues to progress, it will activate functional teams that will provide recommendations related to the operations of a merged system. We will want nursing to be well represented and active on these teams, which will focus specifically on areas like clinical operations, academics and research, and population health.

Throughout this process, we encourage nursing leadership to stay closely in touch with hospital leadership to communicate questions and thoughts from nursing staff. Meanwhile, we will continue to seek the input of our team members in a variety of ways, including our Better Together website, our newsletter, internal and external town hall meetings, and more. We recognize the vital role our nurses play every day but especially in shaping the future of our proposed new system, and we're committed to keeping our nurses updated on any opportunities to be involved.

"What are the plans for the future of pediatrics care?"

A: We see great opportunity to enhance and expand access to pediatric services through our proposed merger across the region. What that looks like specifically is part of the planning work ahead as we first identify gaps in what our communities need versus what either of our organizations offer today and can improve through the proposed merger. We look forward to sharing more information as our planning efforts unfold.

Have a question? Submit it by clicking here or to this email address: info@becomingbettertogether.org.

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Better Together

Wellmont Health System | Mountain States Health Alliance

Wellmont, Mountain States to Seek Public Input on Key Health Issues

Welcome to a special edition of the Better Together newsletter. We have an exciting update to share and wanted you to be among the first to know.

Mountain States Health Alliance and Wellmont Health System officials **are creating four community work groups designed to provide public input** as the two organizations continue to explore the creation of a new, integrated and locally governed entity. Learn more »

The work groups will provide input in solving some of the region's most challenging health issues:

- **Mental Health and Addiction**
- **Healthy Children and Families**
- **Research and Academics**
- **Population Health and Healthy Communities**

Through **BecomingBetterTogether.org**, we invite the community as well as subject matter experts such as nurses and other health professionals, doctors, public health officials and community advocates to

get involved in these four work groups.

The work groups will:

- Begin meeting in July and continue through the end of the year.
- Hold public meetings throughout Northeast Tennessee and Southwest Virginia to seek community input.
- Be led by a subject matter expert and include members from throughout the region who represent a broad variety of experience and perspectives. The group members will be determined soon.
- Be staffed by members of Mountain States and Wellmont along with master's and doctoral level students from East Tennessee State University.
- Provide regular updates as well as final findings to the Integration Council, a group of executive and physician leaders from both systems who are overseeing the analysis and making preparations for the integration of the proposed combined system.

The work groups' findings will be used by East Tennessee State University as part of a deep-dive health needs assessment that will be conducted after the proposed merger between Mountain States and Wellmont is complete. **That assessment will provide a road map for the proposed new health system as it lays out a 10-year plan to improve community health.**

Our organizations have committed to an open process as we consider the creation of a truly new health improvement organization for our region. These work groups **provide a great opportunity for interested organizations and individuals to participate with us** as we develop our strategies for improving the health of our area.

Visit BecomingBetterTogether.org to learn more about how to get involved.

In the coming weeks and months, the website will be updated to include the latest work group news, meeting schedules and more.

As always, if you have questions or thoughts to share, let us know.

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Better Together

Wellmont Health System | Mountain States Health Alliance

Wellmont, Mountain States Announce Community Health Work Groups Meeting Dates and Chairs

Earlier this summer, Wellmont Health System and Mountain States Health Alliance announced an exciting new initiative to seek the public's input as the organizations work together to try to solve some of our region's most important health issues: **Mental Health & Addiction; Healthy Children & Families; Research & Academics; and Population Health & Healthy Communities.**

We are overwhelmed and excited by how many people in our community expressed interest in getting involved in this important discussion – over 100 people signed up to participate through our website.

Today, we're excited to share the next steps in this initiative. Several local community leaders have been selected as chairpersons to lead the work groups, and the first of a series of community meetings have been scheduled.

Eight community leaders have agreed to serve as chairpersons of the four work groups:

- Mental Health & Addiction: Dr. Teresa Kidd, president and CEO of

Frontier Health, and Eric Greene, senior vice president of Virginia services for Frontier Health;

- Healthy Children & Families: Dr. David Wood, chair of the department of pediatrics at East Tennessee State University and chief medical officer of Niswonger Children's Hospital, and Travis Staton, CEO of United Way of Southwest Virginia;

- Population Health & Healthy Communities: Dr. Randy Wykoff, dean of ETSU's College of Public Health, and Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City;

- Research & Academics: Dr. Wilsie Bishop, vice president for health affairs and chief operating officer of East Tennessee State University, and Jake Schrum, president of Emory & Henry.

Additionally, the first two community round table meetings will take place on August 13th and 20th:

- **August 13, 5:30 – 7:30 p.m.**
  Tennessee College of Applied Technology
  425 TN-91, Elizabethton, Tenn.

- **August 20, 5:30 – 7:30 p.m.**
  Southwest Virginia Higher Education Center
  One Partnership Circle, Abingdon, Va.

We hope you will join us for one of these meetings, as well as future meetings as they are scheduled throughout Northeast Tennessee and Southwest Virginia. If you plan to attend, **we ask that you submit a quick RSVP online**. Your RSVP is encouraged but not required.

Wellmont and Mountain States continue to explore the creation of a new, integrated and locally governed health system designed to be among the best in the nation. The discussions to occur and the findings of the community health work groups will be incredibly valuable as we plan for a

bright future for health care in our region.

Visit BecomingBetterTogether.org to stay up to date on the latest news regarding the work groups, the proposed merger and more.

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Wellmont Health System | Mountain States Health Alliance

Wellmont and Mountain States continue to make progress on exploring the creation of a new, integrated and locally governed health system.

Over the past few months, we've been humbled by the outpouring of support we've received from the community.

It's exciting to see that so many people in our region believe in the vision of our proposed future health system and the benefits of a local solution to tackling our regional health care needs. In fact, we've had more than 10,000 unique visitors to BecomingBetterTogether.org. We want to thank you for your thoughtful questions and support for this potential new health system.

Additionally, we've received numerous public statements of support from community and business leaders, academic leaders, elected officials and more, such as East Tennessee State University, the local Chambers of Commerce, Eastman Chemical Company and the Tennessee Medical Association. You can view the latest media clips, including supportive op-eds and letters to the editor, here.

News & Updates

Community Health Work Groups Initiative

This month, we launched the community work groups initiative in partnership with ETSU as a way to gain public input in developing a 10-year health improvement plan for the region. These groups, led by subject matter experts, will continue to meet throughout Northeast Tennessee and Southwest Virginia through the end of the year. We are very encouraged by the almost 100 community members who joined us in both Elizabethton and Abingdon to kick off this important work.

Visit BecomingBetterTogether.org to learn more about how to get involved and to RSVP for an upcoming meeting near you.

Proposed Merger Progress

We continue to pursue due diligence and other important steps toward a potential agreement to combine the health systems, including measuring the likely cost and quality benefits, **determining the structure of the proposed system** and **engaging with key stakeholders** such as employees, physicians and the community to understand what's important to them regarding the proposed system and our vision for the future.

There are several upcoming milestones in the process to finalize our proposed partnership.

- This fall, we expect to execute a **Definitive Agreement** (DA) between our two organizations, which is the next step in the process toward seeking government approval to merge.
- With that in mind, we will also file a **Letter of Intent** (LOI) to the Department of Health in Tennessee, which is a required first step before we submit a COPA (Certificate of Public Advantage) application in Tennessee.
- There is still a lot of work ahead, and we're committed to keeping you informed of the progress we're making. We'll continue sharing news as we have it in a variety of ways, including through updates to BecomingBetterTogether.org.

Finally, in case you missed it, Bart Hove, president and CEO of Wellmont,

and Alan Levine, president and CEO of Mountain States, answered viewer questions about the proposed merger on WJHL Monday. See what they had to say here.

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Better Together

Wellmont Health System | Mountain States Health Alliance

Wellmont, Mountain States Take Important Next Steps in Proposed Merger Process

We have an update to share and wanted you to be among the first to know. **Wellmont and Mountain States have filed a letter of intent (LOI) with the Tennessee Department of Health**, indicating we will submit an application for a Certificate of Public Advantage (COPA) this fall. **In Virginia, we have submitted a similar letter of intent with the Southwest Virginia Health Authority**, signaling our intent to request approval by the commonwealth of the anticipated cooperative agreement between the two systems.

These important filings show **we are moving forward** with the state regulatory approval processes, but we still have many more steps to complete in the coming months.

A COPA in Tennessee and the cooperative agreement approval process in Virginia will allow Wellmont and Mountain States to merge, with the states actively supervising the proposed new health system to ensure it complies with the provisions of the COPA intended to contain costs and sustain high quality, affordable care.

We appreciate the great work of the officials in both states as they create the guideposts that will oversee our proposed

merger. Tennessee's Department of Health recently released interim regulations governing COPAs in Tennessee, and Virginia's Department of Health is finalizing rules to oversee similar cooperative agreements in that state.

Next, the two organizations will finalize a definitive agreement, which is another formal step in the process to solidify the proposed partnership. The date for expected completion of the merger has not been set but will not occur before state approval has been granted.

We're encouraged by our great progress. **In fact, the more we work together, the more excited we become about building a new approach to health care in our region.** We promise to keep everyone informed as we reach coming milestones.

Read the news release here and view the LOIs here.

Community Support Continues

We want to thank everyone for the support we've received in recent months. Earlier this month, a group of 25 physicians, community members and business leaders attended a meeting hosted by the Virginia Department of Health to express their opinions on the proposed regulations as well as their support for the proposed merger.

Here is what a few attendees had to say:

- "Leonard Companies has been doing business in Southwest Virginia for 61 years. As business people and citizens of the area that will be affected we support the merger of these two health care systems. We believe that this consolidation will assist the five-state region by enhancing quality physician recruitment, provide a broader array of medical specialists available to the rural communities of our area, and assist in much needed economic development for the region." - **Dave Leonard, II, vice president, Leonard Land and Livestock**

- "A properly regulated environment will allow the entities to bring high quality healthcare to the people in our region at an affordable cost. This is a unique situation that will help ensure the future of healthcare in Southwest Virginia." **- Martin Kent, president and chief operating officer, The United Company**

- "My Chamber of Commerce represents hundreds of businesses. One important factor in having a healthy and thriving economy is having a healthy community. Mountain States Health Alliance and Wellmont Health System are working on a proposed merger. Providing affordable, high-quality healthcare with broad access is the vision. Healthcare is complicated and the regulations…will give these two organizations the ability to become a single entity with one goal: making the people in our region healthy." **- Beth Rhinehart, president and CEO, Bristol, Tennessee and Virginia Chamber of Commerce**

- "I see every day how healthcare is changing. I support the proposed merger…because in today's complicated and rapidly changing healthcare landscape it's important to look for ways to improve care and keep costs down."**- Skip Skinner, executive director, LENOWISCO**

- "As a physician, I have seen many changes in healthcare both locally and across the country, many of them driven by regulatory reform. The … legislation passed in Virginia last year was an important step towards ensuring healthcare remains available to people in our area and that costs remain competitive. The proposed merger between Wellmont Health System and Mountain States Health Alliance is just one example of what can be achieved under the enabling legislation and a sound regulatory environment." **- Dr. Maurice Nida, Norton, Virginia physician with Wellmont Medical Associates**

These are just a few of the voices of the many local people and organizations that have expressed support for what Mountain States and Wellmont are working to accomplish through the proposed merger.

These expressions of support are the latest in a series of positive statements

from our community, which has included East Tennessee State University, the local Chambers of Commerce, Eastman Chemical Company and the Tennessee Medical Association. Additionally, you can view the latest media clips, including supportive op-eds and letters to the editor, here.

Visit BecomingBetterTogether.org for the latest news and updates.

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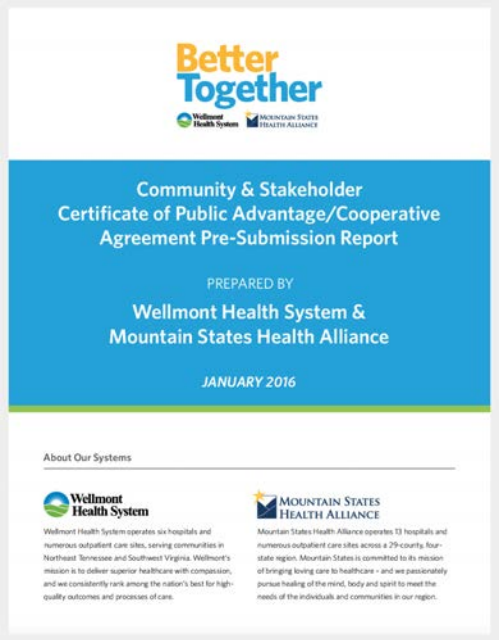
Better Together

Wellmont Health System | Mountain States Health Alliance

Wellmont, Mountain States Share Exciting Commitments to Improve Region's Health



Today, **we're excited to share a public report proposing important commitments** about how we will operate and uniquely serve our community as a new health system. **This report is the result of more than nine months of extensive work by physician leaders, board members and executives** from Wellmont and Mountain States, and **hundreds of conversations with people all across our region** about the area's critical health needs and how best to address them.

The report describes our commitment to make a series of transformational investments to improve health in the region. These investments will be achieved through financial efficiencies gained through the proposed merger and the proposed new health system's commitment to reinvest those savings for community benefit and health improvement.

The report outlines important commitments to positively impact health

care and economic development in the region as a combined system in six key areas:

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

The pre-submission report is the latest step in the process for the proposed merger of the two health systems. Next, we expect to file applications for a COPA in Tennessee and a cooperative agreement in Virginia in late January after a period of public comment on the report. The applications will initiate the state review process, which is expected to extend into the late summer of 2016.

Since we announced our proposed merger in April, we have been grateful for the outpouring of support we have received throughout the region. As we move forward, we'll continue to provide updates in a variety of ways.

Know that we remain committed to the creation of a brand new health system designed to meet the unique needs of our region, both today in the future. In fact, the further we move down this path, and as additional details of what we'll be able to achieve together are clarified, the more excited we are about this innovative vision.

Our region has a once in a lifetime opportunity to create a lasting legacy of improved health by pursing a merger between Wellmont and Mountain States. With the approval of the states under a COPA in Tennessee and a cooperative agreement in Virginia, the savings realized by reducing unnecessary duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially.

To learn more, please visit BecomingBetterTogether.org to review the commitments, download the full report, and provide your thoughts and feedback.

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Record of Community Stakeholder and Consumer Views

of the Proposed Cooperative Agreement

ATTACHMENT C

Internal Town Hall Presentations

Better Together

Wellmont Health System | Mountain States Health Alliance

Leadership Team Discussion

Moving Forward with Vision

Leadership Team Presentation – April 2015

What We Are Announcing

Wellmont Health System and Mountain States Health Alliance have agreed to exclusively explore the creation of a **new, integrated and locally governed health system** designed to be among the best in the nation and address the serious health issues that affect our region.

Timeline

- Tuesday (3/31)
  - WHS Board Meeting
- Wednesday (4/1)
  - Senior Leadership Call
  - MSHA Board Meeting
  - Physician Leadership Meeting
  - Select VIP Calls
  - Anticipated Signing of Letter of Intent
- Thursday (4/2)
  - VIP Calls
  - Community Board Call
  - Internal Memo
  - Press Release; Invite to Press Briefing
  - Press Briefing
  - Town Halls throughout the System
  - Medical Staff Meetings

Wellmont Health System | Mountain States Health Alliance

Your Role

- Credible source of information
- Leader of town halls and other key meetings
- Sounding board for employees and physicians
- Liaison back to leadership about the pulse

Wellmont Health System | Mountain States Health Alliance

Key Messages

Better Together

Wellmont Health System | Mountain States Health Alliance

We have a great vision.

- As a combined system, we would work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's, and to make sure those who need healthcare services today can access the best care available in the nation.

We are creating something new.

- Neither organization is acquiring the other one.
- We will have a new name.
- We will have a new board, equal parts Wellmont and Mountain States, plus two independent members and the President of ETSU.

Wellmont Health System | Mountain States Health Alliance

Apart, we face a number of challenges.

- Significant national industry challenges.
  - Increasing reimbursement cuts, the decline of inpatient volumes, constrained revenue, the move of services to the outpatient setting, and the increasing difficulty in recruiting and retaining physicians.
- Plus, our region suffers from serious health issues that need to be addressed.
  - Some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country; an epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment; and we admit more people to the hospital per thousand than most other areas of the nation.

Together, we will make our region healthier.

- By working together in an integrated system, we can redirect spending away from wasteful duplication that has not added value, and instead invest in what evidence has shown will help make our region healthier while controlling costs.

Wellmont Health System | Mountain States Health Alliance

We will be one of the most attractive systems for physicians and team members nationally.

- Physicians will have a strong voice during the integration process and will help guide the formation of the new system.
- A counsel of physician leaders from both organizations will be formed to address matters related to the provision of clinical services and other medical staff matters.
- All existing contracts and medical privileges will be honored for employed and independent physicians in good standing.
- Our pay and benefits will be competitive in order to attract the best and brightest team members.
- No major layoffs are anticipated.

Wellmont Health System | Mountain States Health Alliance

There is much planning work to do.

- Now, we enter a planning period for several months.
- This work will be led by a Joint Board Task Force and an Integration Council, including executive and physician leaders from both systems.
- If we decide to proceed with a definitive agreement, we will then enter a government approval phase likely through the end of 2015.

Wellmont Health System | Mountain States Health Alliance

What is a COPA?

- We will pursue government approval under the COPA (Certificate of Public Advantage) statute in TN.
- A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that we continue to benefit the community by providing healthcare that is affordable, accessible, cost-efficient and high-quality.
- In VA, we will pursue a process similar to a COPA defined by a proposed statute that has been passed by the legislature and awaits the governor's signature.

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Until then…

- During the due diligence and government approval phases, both Mountain States and Wellmont will continue "business as usual" as **two separate and independent organizations.**

Wellmont Health System | Mountain States Health Alliance

Better Together

Wellmont Health System

Mountain States Health Alliance

Joint Announcement Presentation – April 2015

What We Are Announcing

Wellmont Health System and Mountain States Health Alliance have agreed to exclusively explore the creation of a **new, integrated and locally governed health system** designed to be among the best in the nation and address the serious health issues that affect our region.

We are creating something new.

- This is a **merger** – not an acquisition by either organization – and we will have a **new name**.
- A **new board** will have equal representation from Wellmont and Mountain States, and two new independent members, plus the President of ETSU (non-voting).
- The new organization will be managed by an **executive team** with representatives from each organization: Executive Chairman & President Alan Levine, CEO Bart Hove, COO Marvin Eichorn and CFO Alice Pope.

Wellmont Health System | Mountain States Health Alliance

Apart, we face a number of challenges.

- Significant industry and local business challenges
  - Increasing reimbursement cuts, the decline of inpatient volumes, the move of services to the outpatient setting, the increasing difficulty in recruiting and retaining physicians
- Our region's serious health issues
  - Some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country
  - Epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment
  - More people admitted to the hospital per thousand than most other areas of the nation

Wellmont Health System | Mountain States Health Alliance

Together, we will make our region healthier.

- The cost of this poor health is not sustainable, and **we must take transformational steps to resolve these issues**.
- By working together in an integrated system, we can redirect spending away from wasteful duplication that has not added value, and instead invest in what evidence has shown will help **make our region healthier while controlling costs**.

Wellmont Health System | Mountain States Health Alliance

Together, we have a great vision.

As a combined system, we would work to unite the resources of both systems with one common purpose – to **make the next generation of this region healthier** than today's, and to make sure those who need healthcare services today can access the **best care available** in the nation.

Wellmont Health System | Mountain States Health Alliance

We will be one of the best healthcare employers in the country.

- We will nurture a **culture that promotes employee satisfaction** and opportunity for professional growth.
- **Physicians will have a strong voice** during the integration process and will help guide the formation of the new system.
- A **council of physician leaders** from both organizations will be formed to address matters related to the provision of clinical services and other medical staff matters.

Wellmont Health System | Mountain States Health Alliance

A COPA affirms our commitment to the community.

- We will pursue approval under the **Certificate of Public Advantage** statute in TN and a similar process in VA.
- A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that it continues to benefit the community by providing healthcare that is affordable, accessible, cost-efficient and high-quality.

Wellmont Health System | Mountain States Health Alliance

There is much planning work to do.

- A **joint board task force** will oversee the effort, and an **integration council**, with executive and physician leaders from both systems, will oversee the integration analysis and further develop integration plans.
- Following a definitive agreement, we will then enter a government approval phase likely **through the end of 2015**.

Wellmont Health System | Mountain States Health Alliance

Until then…

- Nothing changes today.
- During the due diligence and government approval phases, both Mountain States and Wellmont will continue "business as usual" as **two separate and independent organizations.**

Wellmont Health System | Mountain States Health Alliance

Keeping You Informed

- We promise to keep everyone informed.
  - We'll share ongoing updates in our regular internal communications, on the Intranet, in town hall meetings, etc.
  - We are launching a new website as a resource for news, FAQs and more: **www.BecomingBetterTogether.org**.
  - We welcome your questions and comments along the way. Send them to **info@becomingbettertogether.org**.

Wellmont Health System | Mountain States Health Alliance

Some Key Questions

Better Together

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How will we bring our two distinct organizations and cultures together?

Culture and heritage are critically important to both organizations. That's why we are creating a joint board task force, an integration council and a clinical council. Over the next many months, our board members and executive and physician leaders will be investing themselves in the work of exploring how to weave our operations and cultures together, so we benefit from the best of both.

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When would the merger be finalized?

We believe a merger can be finalized by the end of 2015, once all steps are completed.

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What does this mean for jobs?

There are a number of details yet to be determined, and this is the work before leadership and the integration council over the coming months. What we do know today is that our combined organization would be committed to being one of the best healthcare employers in the country and to nurture a culture that promotes employee satisfaction and opportunity for professional growth. We promise to share more information as soon as it's available.

Wellmont Health System | Mountain States Health Alliance

Will physicians need to reapply for privileges?

No. If we merge, all medical staff members in good standing would maintain their medical staff privileges.

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Will projects planned be put on hold while this merger is explored?

Today, nothing changes as both Wellmont and Mountain States continue as separate and independent organizations. It's "business as usual" for both of us.

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How long before we start to see changes resulting from a merger?

Nothing changes until this transaction is complete, which is likely to take us through the end of 2015. After that time, there will still be significant work before us. Our commitment is to manage any change carefully and methodically, but also expeditiously to capture the cost, quality and access benefits as quickly as possible starting from day one of the new health system. It is for this reason that we will begin appropriate integration planning – but not implementation – prior to closing.

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What does this mean for our community?

This would be a significant step forward for patient care, wellness, affordability and health education in our region. We would:

- Invest in **high-level specialty services**, allowing more people to receive the care they need close to home;
- Work with ETSU and our academic partners to conduct a comprehensive regional health needs assessment; then work hand-in-hand to **tackle some of the most important health issues our region faces**, including high rates of smoking, obesity, physical inactivity and the adverse health effects that follow, such as high blood pressure, diabetes, heart disease and cancer;
- Work to **improve access to substance abuse and mental health services** in the region;
- Work to eliminate unnecessary duplication in our operations, enabling us **to invest more in better coordinating patient care, improving quality and enhancing access** throughout the communities we serve; and
- Work with academic institutions, such as ETSU, to **strengthen the pipeline of physicians and allied health professionals, and to attract research jobs and investments** in our region.

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Other questions?

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[INSERT MEETING TITLE]

[INSERT DATE]

Town Hall Presentation Template – June 2015

Today's Agenda

- Quick Recap: Our Proposed Partnership
- Where We Are Today
- What's Next
- Q&A

First – Thank You.

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Quick Recap: Our Proposed Partnership

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The Proposed Transaction

Wellmont Health System and Mountain States Health Alliance have agreed to exclusively explore the creation of a **new, integrated and locally governed health system** designed to be among the best in the nation and address the serious health issues that affect our region.

It's an opportunity for our two organizations to come together and build something **brand new** that reflects what our community really needs – today and in the years ahead.

The Proposed Transaction

- This is a **merger** – not an acquisition by either organization – and we will have a **new name**.
- The new organization's **executive team** will include representatives from each organization:
  - Executive Chairman & President Alan Levine
  - CEO Bart Hove
  - COO Marvin Eichorn
  - CFO Alice Pope
- A **new board** will have equal representation from Wellmont and Mountain States, two new independent members and the president of ETSU (nonvoting).

Challenges We Face: Industry and Local

Increasing reimbursement cuts

The decline of inpatient volumes

The move of services to the outpatient setting

Increasing difficulty in recruiting and retaining physicians

And more

Challenges We Face: Regional Health Issues

Some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country.

Epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment.

More people admitted to the hospital per thousand than most other areas of the nation.

Our Vision

As a combined system, we will unite the resources of both systems with one common purpose – to **make the next generation of this region healthier** than today's and to make sure those who need health care services today can access the **best care available** in the nation.

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Our Vision

Together…

As a single integrated health system and significant employer, our new system will be uniquely able to provide the people we serve with even **higher quality, more affordable care.**

We will **aim to be among the best health systems in the nation,** known for outstanding clinical outcomes, superior patient experience and affordability.

We will be one of the **most attractive health systems for physicians and team members.**

We will **partner with physicians and clinically integrate** to derive new quality and value for the patients, businesses and payors who rely on us.

We will achieve **long-term financial stability and sustainability** through the capture of major merger-specific cost-efficiencies, wise stewardship of resources and sound fiscal management.

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Where We Are Today

The Process for Coming Together

- Pursue approval under the **Certificate of Public Advantage** statute in TN and a similar process in VA.
  - A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that it continues to benefit the community by providing care that is affordable, accessible, cost-efficient and high-quality.
- **COPA legislation update:**
  - TN: Gov. Haslam signed amendments to existing COPA statute.
  - VA: New law goes into effect July 1, 2015.

The Process for Coming Together

Recently announced the members of two planning groups:

Joint Board Task Force:
Representatives from both system boards; will serve as liaison to boards and provide guidance during exploration process.

Integration Council:
Executive and physician leaders from both systems; will oversee the integration analysis and further develop integration plans.

IC and JBTF Focus Areas

- **Working to solidify the proposed partnership**
  - Developing Definitive Agreement
  - Preparing COPA application
  - Working with regulatory agencies and TN/VA
- **Determining the structure of the proposed system**
  - Developing bylaws/structure for potential system; governance audit
  - Conducting study to explore cost savings to refocus resources for community benefit
  - Integration planning: brand assessment; cultural audit; employee focus groups
- **Engaging with key stakeholders**
  - Includes employees, physicians, community
  - To understand what's important to you regarding proposed system and its vision
  - One way we'll seek input is through community work groups initiative

Community Input Work Groups

Mental Health & Addiction

Healthy Children & Families

Research & Academics

Population Health & Healthy Communities

www.becomingbettertogether.org/get-involved

About the Work Groups

The work groups will provide input in solving some of the region's most challenging health issues. The work groups will:

- Begin meeting in July and continue through the end of the year.
- Hold public meetings throughout Northeast Tennessee and Southwest Virginia to seek community input.
- Led by a subject matter expert; will include members from throughout the region who represent a broad variety of experience and perspectives.
- Staffed by members of Mountain States and Wellmont along with master's and doctoral level students from ETSU.
- Provide regular updates as well as final findings to the Integration Council.

Community Support

MORE THAN 8,000 UNIQUE VISITORS TO THE WEBSITE

500+ EXTERNAL SUBSCRIBERS TO THE NEWSLETTER

NUMEROUS PUBLIC STATEMENTS OF SUPPORT FROM COMMUNITY AND BUSINESS LEADERS, ACADEMIC LEADERS, ELECTED OFFICIALS AND MORE

ACTIVELY ENGAGING IN THE COMMUNITIES WE SERVE

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"The Chambers of Commerce … endorse the proposed merger of Wellmont Health System and Mountain States Health Alliance to an integrated single system. We believe this offers the best opportunity for the betterment of our region's healthcare."

The Chambers of Commerce of Kingsport, Bristol and Johnson City/Jonesborough/Washington County

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"Eastman supports the decision to unify the systems in an effort to improve the quality and affordability of and access to health care in the region."

CeeGee McCord, Eastman Chemical Company

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"The Tennessee Nurses Association embraces the decision as one that will improve the quality of health care in our region, control spiraling costs, and better address the chronic health care issues facing this state."

Teresa A. Martin, MSN, FNP-BC, District President, on behalf of District 5, Tennessee Nurses Association

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"Combining strengths, assets and liabilities would enable these systems to focus more on quality, population health management, mental health programs and other services benefiting the entire region."

Douglas J. Springer, MD, immediate past president on behalf of the Tennessee Medical Association

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What's Next

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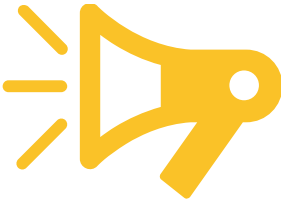
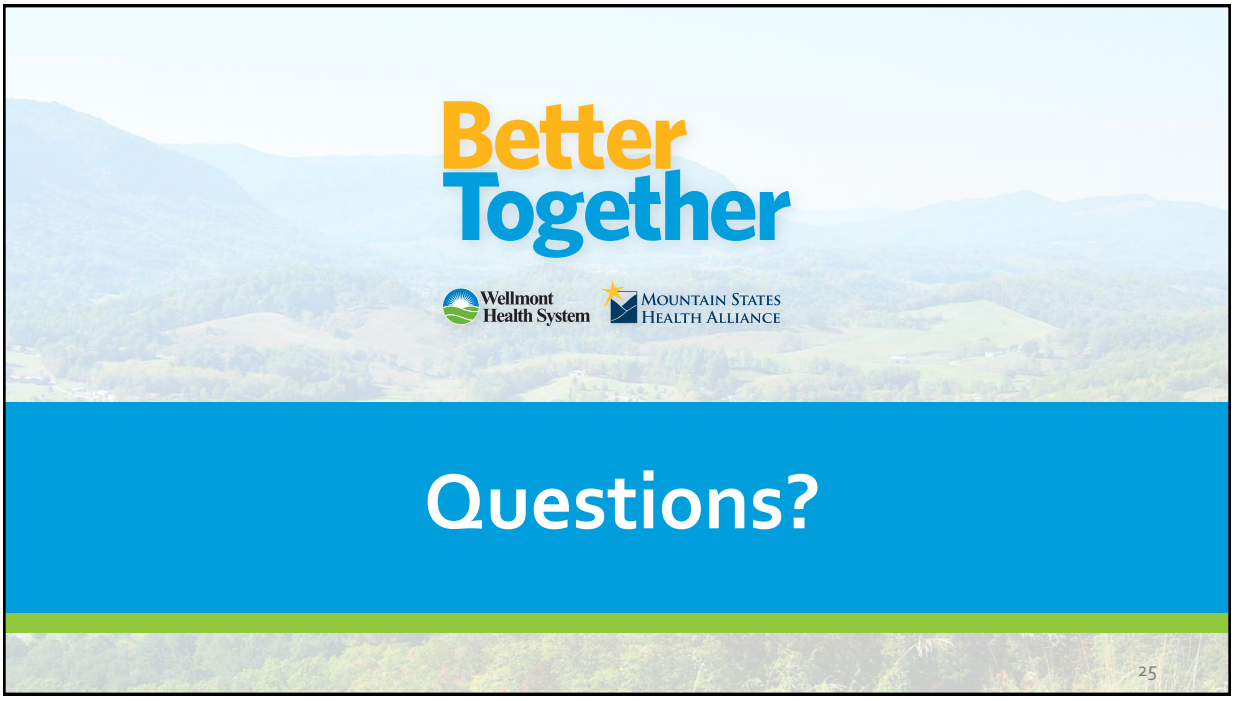
What's Ahead

- Following a definitive agreement, we will enter a government approval phase that will likely take us **through the end of 2015**.
- During the due diligence and government approval phases and until the moment of closing, both Mountain States and Wellmont will continue "business as usual" as **two separate and independent organizations.**

Keeping You Informed

- Committed to sharing ongoing updates
- Website: **BecomingBetterTogether.org**
  - Latest news, FAQs, resources, and more
- The Better Together newsletter
  - Distributed internally and externally
- Send questions and comments to: **info@BecomingBetterTogether.org**

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Wellmont
Health System
Mountain States
Health Alliance
Questions?
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Proposed Merger Update

Town Hall Presentation Template – August 2015

1

The Proposed Transaction

- This is a **merger** – not an acquisition by either organization – and we will have a **new name**.
- The new organization's **executive team** will include representatives from each organization:
  - Executive Chairman & President Alan Levine
  - CEO Bart Hove
  - COO Marvin Eichorn
  - CFO Alice Pope
- A **new board** will have equal representation from Wellmont and Mountain States, two new independent members and the president of ETSU (nonvoting).

Our Vision

Together…

As a single integrated health system and significant employer, our new system will be uniquely able to provide the people we serve with even **higher quality, more affordable care.**

We will **aim to be among the best health systems in the nation,** known for outstanding clinical outcomes, superior patient experience and affordability.

We will be one of the **most attractive health systems for physicians and team members.**

We will **partner with physicians and clinically integrate** to derive new quality and value for the patients, businesses and payors who rely on us.

We will achieve **long-term financial stability and sustainability** through the capture of major merger-specific cost-efficiencies, wise stewardship of resources and sound fiscal management.

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Where We Are Today

We are making great progress.

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Working Closely with State Officials

- **Working with officials in both states** as we continue to gain clarity around the regulatory approval process required to finalize our proposed partnership.
- Pursue approval under the **Certificate of Public Advantage** statute in TN and a similar process in VA.
  - A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that it continues to benefit the community by providing care that is affordable, accessible, cost-efficient and high-quality.
- Both states recently issued **interim rules** governing COPAs in TN and similar cooperative agreements in VA.

What's Ahead

- There are **several upcoming milestones** in the process to finalize our proposed partnership.
  - This fall, we expect to execute a **Definitive Agreement (DA)** between our two organizations, which is the next step in the journey to solidify our proposed partnership.
  - With that in mind, we will also file a **Letter of Intent** (LOI) to the Department of Health in Tennessee in the coming month, which is a required first step before we submit a COPA application in Tennessee at a minimum 45 days later.

Working with the Community

Mental Health & Addiction

Healthy Children & Families

Research & Academics

Population Health & Healthy Communities

www.becomingbettertogether.org/get-involved

Keeping You Informed

- Committed to sharing ongoing updates
- Website: **BecomingBetterTogether.org**
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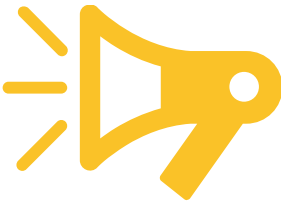

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Questions?

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Mountain States Health Alliance

Town Hall Update

January 2016

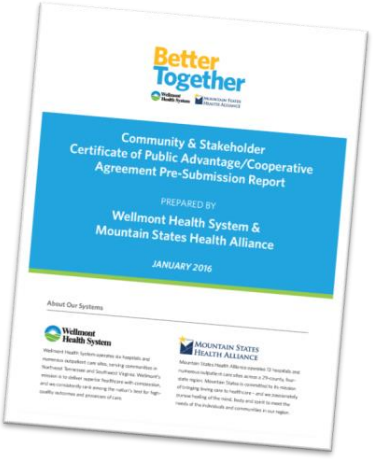
Town Hall Presentation: Pre-Submission Report

Key Milestones Timeline

Pre-Submission Report Overview

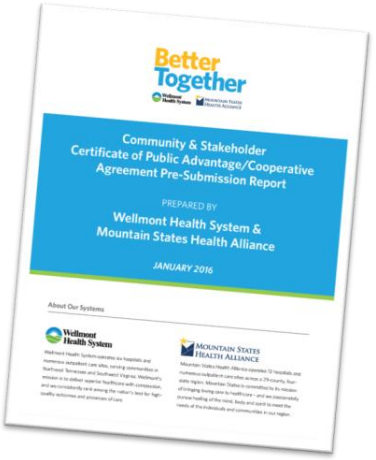
- Released January 7, 2016
- **Public report designed for the community; comments are welcome**
- To be followed by filing COPA/cooperative agreement applications

Full Report Available:
BecomingBetterTogether.org/report



Report Highlights

- Result of **more than nine months** of extensive work
- Outlines important commitments in **six key areas**
- The report also describes a **series of transformational investments** we will make as a combined system over the next 10 years to improve health in the region
  - Made possible through financial efficiencies to be achieved



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Commitments & Investments

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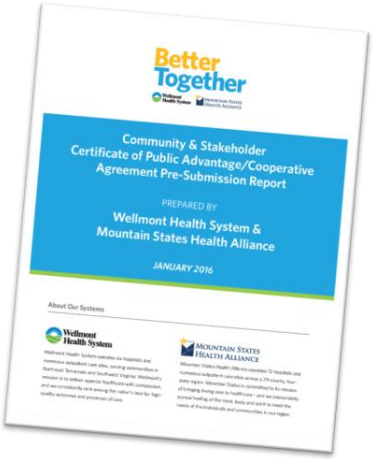
Commitments

- **Improve Community Health**
- **Enhance Health Care Services**
- **Expand Access and Choice**
- **Improve Health Care Value: Managing Quality, Cost and Services**
- **Invest in Health Research and Graduate Medical Education**
- **Attract and Retain a Strong Workforce**



Improve Community Health

Invest $75 million over 10 years in programs to address common health issues in children and adults

- Creating strong starts for children
- Living well in the community
- Promoting a drug-free community
- Decrease avoidable hospital admission and ER use

Improve Community Health

Strong starts for children
- Childhood obesity
- Birth outcomes
- Type 1 and 2 diabetes
- Neonatal abstinence syndrome
- Third-grade reading proficiency

Living well in the community
- Diabetes
- Cardiovascular disease
- Breast, cervical, colorectal and lung cancer

Drug-free communities
- Prevent substance abuse in youth
- Prevent tobacco use in youth
- Reduce overprescription of painkillers
- Combat drug addiction through:
  - Crisis management
  - Residential treatment
  - Community-based support

Connect high-need, high-cost uninsured individuals to care
- Intensive case management
- Primary care
- Behavioral health crisis management
- Residential addiction treatment
- Intensive outpatient treatment services

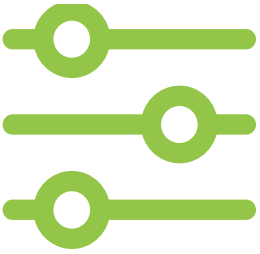
Enhance Health Care Services

Invest $140 million over 10 years in needed specialty services

- Expand residential and outpatient addiction recovery programs and community-based mental health services
  - Mobile crisis management
  - Intensive outpatient services
  - Addiction resources for adults and children
- Recruit and retain pediatric subspecialists in accordance with Niswonger Children's Hospital physician needs assessment
- Develop dedicated emergency facilities for children in Kingsport and Bristol and deploy pediatric telemedicine to rural communities
- Develop a plan to meet physician staffing needs in underserved and rural areas

Expand Access and Choice

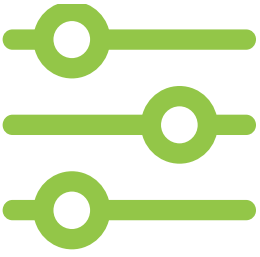
- Maintain three full-service tertiary hospitals in Johnson City, Kingsport and Bristol
- Repurpose some current facilities to develop and enhance access to needed services
- Ensure physicians are able to practice where they choose and patients are able to seek care where they choose



Expand Access and Choice

The new health system will value a robust and successful independent physician community.

- Work with the independent physician community to build an array of service offerings
- Maintain open medical staffs at all facilities, with possible exception of hospital-based physicians
- Not require independent physicians to practice exclusively at the new health system's hospitals
- Not take steps to prohibit independent physicians from participating in health plans of their choice



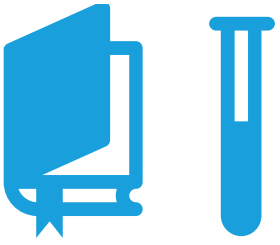
Improve Health Care Value

- Reduce the pace of health care cost growth by placing **limits on negotiated rates with insurers**
- **Invest approximately $150 million** over 10 years to facilitate electronic health information exchange and develop a common electronic health record platform
- Develop a regionwide clinical services network, collaborating to improve health outcomes
- Work in good faith with insurers to protect consumers' network access

Expand Health Research & Graduate Medical Education

The new health system will invest $85 million over 10 years to support academics and research

- Work with partners in TN and VA to develop and grow academic and research opportunities
- Support post-graduate health care training
- Increase residency slots
- Create new specialty fellowship opportunities
- Strengthen the pipeline and preparation of health professionals



Attract and Retain a Strong Workforce

- Continue to provide competitive pay and benefits
- Provide credit for accrued vacation and sick leave
- Honor prior service credit for eligibility and vesting under employee benefit plans maintained by each organization
- Combine the best of each organization's career development opportunities

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The Path We're Pursuing

The Path We're Pursuing

Our Path

State oversight.

Through a COPA/cooperative agreement, the proposed organization must be approved by both states, and then be actively supervised to ensure it benefits the community by providing affordable, accessible, cost-efficient and high-quality care for years to come.

The Alternative

No enforceable protections for the community.

Standard "out-of-market" acquisitions of hospitals do not generally include strict enforcement mechanisms to protect consumers or ensure the community benefits.

The Path We're Pursuing

Our Path

A health system designed for our region.

Together, we will create efficiencies, expand services, increase choices, improve access to care, and address the serious health issues that affect our region and matter most to the people we serve.

The Alternative

No accountability.

An outside health system could be free to take merger-related savings and jobs out of our communities. That organization would face no requirement or local accountability to make the investments in community health that our region so desperately needs.

We believe our proposed alternative is better.
It is the only model that maintains local governance, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region and invests those dollars in the improved health of the people we serve while also preserving local jobs.

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Next Steps

- Expect to announce reaching a **Definitive Agreement** and **filing COPA/cooperative agreement applications** in late January.
- **Working with officials in both states** to ensure applications are deemed complete; review period will likely extend into the late summer of 2016.

Wellmont Health System | Mountain States Health Alliance

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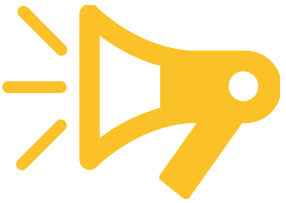
Keeping You Informed

- Committed to sharing updates
  - Visit **BecomingBetterTogether.org** for the latest news, FAQs, resources and more
  - Ongoing newsletters/internal updates
- Send general questions and comments to: **info@BecomingBetterTogether.org**
- Visit **BecomingBetterTogether.org/report** to review and provide feedback on the pre-submission report



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Questions?

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Record of Community Stakeholder and Consumer Views

of the Proposed Cooperative Agreement

ATTACHMENT D

Community Presentations and Materials

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Wellmont Health System

Mountain States Health Alliance

Johnson City Chamber of Commerce Board Meeting

May 19, 2015

Thank you.

Better Together

Wellmont Health System

Mountain States Health Alliance

Today's Discussion

- The Proposed Transaction
- The Challenges We Face
- Our Vision
- The Process for Coming Together
- What's Ahead
- Community Support
- Keeping You Informed

The Proposed Transaction

Wellmont Health System and Mountain States Health Alliance have agreed to exclusively explore the creation of a **new, integrated and locally governed health system** designed to be among the best in the nation and address the serious health issues that affect our region.

It's an opportunity for our two organizations to come together and build something **brand new** that reflects what our community really needs – today and in the years ahead.

The Proposed Transaction

- This is a **merger** – not an acquisition by either organization – and we will have a **new name**.
- The new organization's **executive team** will include representatives from each organization:
  - Executive Chairman & President Alan Levine
  - CEO Bart Hove
  - COO Marvin Eichorn
  - CFO Alice Pope
- A **new board** will have equal representation from Wellmont and Mountain States, two new independent members and the president of ETSU (nonvoting).

Challenges We Face: Industry and Local

Increasing reimbursement cuts

The decline of inpatient volumes

The move of services to the outpatient setting

Increasing difficulty in recruiting and retaining physicians

And more

Challenges We Face: Regional Health Issues

Some of the highest rates of cardiovascular disease, diabetes and pulmonary disease in the country.

Epidemic of addiction and untreated mental illness without access to the right level of inpatient and outpatient treatment.

More people admitted to the hospital per thousand than most other areas of the nation.

Wellmont Health System | Mountain States Health Alliance

Our Vision

As a combined system, we will unite the resources of both systems with one common purpose – to **make the next generation of this region healthier** than today's and to make sure those who need health care services today can access the **best care available** in the nation.

Better Together

Wellmont Health System | Mountain States Health Alliance

Our Vision

Together…

As a single integrated health system and significant employer, our new system will be uniquely able to provide the people we serve with even **higher quality, more affordable care.**

We will **aim to be among the best health systems in the nation,** known for outstanding clinical outcomes, superior patient experience and affordability.

We will be one of the **most attractive health systems for physicians and team members.**

We will **partner with physicians and clinically integrate** to derive new quality and value for the patients, businesses and payors who rely on us.

We will achieve **long-term financial stability and sustainability** through the capture of major merger-specific cost-efficiencies, wise stewardship of resources and sound fiscal management.

The Process for Coming Together

- Pursue approval under the **Certificate of Public Advantage** statute in TN and a similar process in VA.
  - A COPA authorizes us to merge and directs the state to actively supervise our new health system to ensure that it continues to benefit the community by providing care that is affordable, accessible, cost-efficient and high-quality.
- **COPA legislation update:**
  - TN: Awaiting the signature of Gov. Haslam by May 21st to amendments to existing COPA statute.
  - VA: New law goes into effect July 1, 2015.

The Process for Coming Together

Recently announced the members of two planning groups:

Joint Board Task Force:
Representatives from both system boards; will serve as liaison to boards and provide guidance during exploration process.

Integration Council:
Executive and physician leaders from both systems; will oversee the integration analysis and further develop integration plans.

What's Ahead

- We are preparing to **launch a new initiative in partnership with ETSU** to solicit the input of nurses, clinical leaders and community members.
- This input will be crucial as we develop a **10-year plan for a healthier region.**

What's Ahead

- Following a definitive agreement, we will enter a government approval phase that will likely take us **through the end of 2015**.
- During the due diligence and government approval phases and until the moment of closing, both Mountain States and Wellmont will continue "business as usual" as **two separate and independent organizations.**

Community Support

NEARLY 7,000 UNIQUE VISITORS TO THE WEBSITE

500+ EXTERNAL SUBSCRIBERS TO THE NEWSLETTER

NUMEROUS PUBLIC STATEMENTS OF SUPPORT FROM COMMUNITY AND BUSINESS LEADERS, ACADEMIC LEADERS, ELECTED OFFICIALS AND MORE

ACTIVELY ENGAGING IN THE COMMUNITIES WE SERVE

"The Chambers of Commerce … endorse the proposed merger of Wellmont Health System and Mountain States Health Alliance to an integrated single system. We believe this offers the best opportunity for the betterment of our region's healthcare."

The Chambers of Commerce of Kingsport, Bristol and Johnson City/Jonesborough/Washington County

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Wellmont Health System · Mountain States Health Alliance

"Eastman supports the decision to unify the systems in an effort to improve the quality and affordability of and access to health care in the region."

CeeGee McCord, Eastman Chemical Company

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Wellmont Health System · Mountain States Health Alliance

"The Tennessee Nurses Association embraces the decision as one that will improve the quality of health care in our region, control spiraling costs, and better address the chronic health care issues facing this state."

Teresa A. Martin, MSN, FNP-BC, District President, on behalf of District 5, Tennessee Nurses Association

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Wellmont Health System | Mountain States Health Alliance

"Combining strengths, assets and liabilities would enable these systems to focus more on quality, population health management, mental health programs and other services benefiting the entire region."

Douglas J. Springer, MD, immediate past president on behalf of the Tennessee Medical Association

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Wellmont Health System | Mountain States Health Alliance

Keeping the Community Informed

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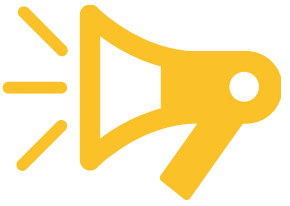

Wellmont Health System | Mountain States Health Alliance

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Wellmont Health System | Mountain States Health Alliance

Questions?

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Wellmont Health System

Mountain States Health Alliance

Kingsport Chamber of Commerce Board Meeting

June 8, 2015

Thank you.

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Wellmont Health System

Mountain States Health Alliance

The Proposed Transaction

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Better Together

Wellmont Health System | Mountain States Health Alliance

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- CeeGee McCord
  Eastman Chemical Company
- Teresa A. Martin,
  MSN, FNP-BC, District President, on behalf of District 5, Tennessee Nurses Association
- Douglas J. Springer,
  MD, immediate past president on behalf of the Tennessee Medical Association
- Craig Becker
  President, Tennessee Hospital Association (Personal endorsement, not official THA endorsement)
- Phil Roe
  U.S. Rep., R-Tenn
- Ron Ramsey
  Tennessee Lt. Gov., R-Blountville
- Dr. Brian Noland
  President, East Tennessee State University

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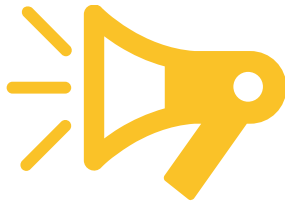

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Questions?

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Community Health Roundtable Meeting

Southwest Virginia Higher Education Center

Aug. 20, 2015

Today's Meeting

- Proposed Merger Update
- Community Health Roundtables
- Your Role
- ETSU's Role
- Getting Started

Thank you for participating in this critical effort.

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Proposed Merger Update

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Challenges We Face: Regional Health Issues

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Our Vision

- Create a true health improvement organization.
- Work with the community to improve the health of the region.
- Solicit community input to tackle our toughest health issues.

The Process for Coming Together

- Pursue approval under the **Certificate of Public Advantage** statute in TN and a similar process in VA.
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- Following a definitive agreement, we will enter a government approval phase that will take us through the end of 2015.

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Community Health Work Groups

Community Input Focus Areas

Mental Health & Addiction

Healthy Children & Families

Research & Academics

Population Health & Healthy Communities

Review the charters for each focus area at BecomingBetterTogether.org

About the Work Groups

The work groups will provide input in trying to solve some of the region's most challenging health issues. Eight community leaders have agreed to serve as chairpersons:

Mental Health & Addiction:

- Dr. Teresa Kidd, president and CEO of Frontier Health
- Eric Greene, SVP of Virginia services for Frontier Health

Healthy Children & Families:

- Dr. David Wood, chair of the department of pediatrics at ETSU and CMO of Niswonger Children's Hospital
- Travis Staton, CEO of United Way of Southwest Virginia

Population Health & Healthy Communities:

- Dr. Randy Wykoff, dean of ETSU's College of Public Health
- Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City

Research & Academics:

- Dr. Wilsie Bishop, VP for health affairs and COO of ETSU
- Jake Schrum, president of Emory & Henry

Wellmont Health System | Mountain States Health Alliance

Your Role

- Roundtables are designed to **give the community an opportunity to provide input** on the most important health issues facing our region.
- Information shared in this meeting will be presented to the work group steering committees for **inclusion in their discussions and reports.**

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Role of ETSU

- We have partnered with ETSU's College of Public Health to facilitate and manage this process.
- ETSU will capture the information presented at roundtable meetings and steering committee meetings and compile a comprehensive report.
- Regular updates and final findings will be provided to the Integration Council.
- The proposed new health system will work with community partners to tackle these important health issues and develop a long-term health improvement plan for the region.

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Getting Started

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WELLMONT HEALTH SYSTEM and MOUNTAIN STATES HEALTH ALLIANCE

have each been privileged for decades to serve you – our families, friends and neighbors. To ensure that tradition continues well into the future, we are exploring **combining our two systems to create a new, integrated and locally governed health system to better meet your healthcare needs.**

BecomingBetterTogether.org

You are our most important priority. Here are just a few of the ways our proposed future system will serve you:

- We'll invest in expanding access to care and services, while also maintaining access in our rural communities, so you can get the care you need close to home – at a cost that's **affordable for you and your family.**
- Wherever you go in our integrated system to receive care – no matter which doctor you see – your care team will have **your medical history at their fingertips** through a systemwide technology platform, ensuring the care you receive takes your overall health into account.
- Together, we'll be better able to coordinate your care between your doctor, the hospital and outpatient services like home health and pharmacy – improving the quality of care you receive and creating a **superior experience** every time you visit us.
- We'll work on improving access to **important services that so many people in our region need,** like substance abuse treatment to stop the cycle of addiction and improved mental health services.
- Working with East Tennessee State University, **we'll identify and tackle head-on important health issues in our region,** like heart disease, addiction and diabetes.
- And much more.

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Wellmont Health System

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BecomingBetterTogether.org

Better Together

Wellmont Health System | Mountain States Health Alliance

After months of research and community engagement, Wellmont Health System and Mountain States Health Alliance are prepared to make a series of important commitments and transformational investments in six key areas over the next 10 years to improve health in the region.

Improve Community Health – We will invest at least **$75 million** in population health improvements to meet the unique health needs of our region through a 10-year plan to be developed with the community and the public health resources at ETSU.

Enhance Health Care Services – We will invest at least **$140 million** to expand community-based mental health services, residential and outpatient addiction recovery programs, and tobacco and substance abuse prevention programs as well as to further support children's and rural health services.

Expand Access and Choice – We will maintain three full-service tertiary hospitals in Johnson City, Kingsport and Bristol; repurpose some current facilities to develop and enhance access to needed services; and ensure physicians are able to practice where they choose and patients are able to seek care where they choose.

Improve Health Care Value – We will invest up to $150 million to implement a common information technology platform to support the regional exchange of health information, connect our hospitals, physicians and other caregivers and allow the combined system to offer higher quality, more convenient and more cost-effective care for patients.

Expand Health Research and Graduate Medical Education – We will invest at least $85 million to develop and grow academic and research opportunities, support post-graduate health care training, and strengthen the pipeline and preparation of health professionals in the region.

Attract and Retain a Strong Workforce – We will offer competitive pay and benefits to attract and retain the best and brightest team members, and combine the best of each organization's career development opportunities – enabling us to become one of the top health system employers in the country.

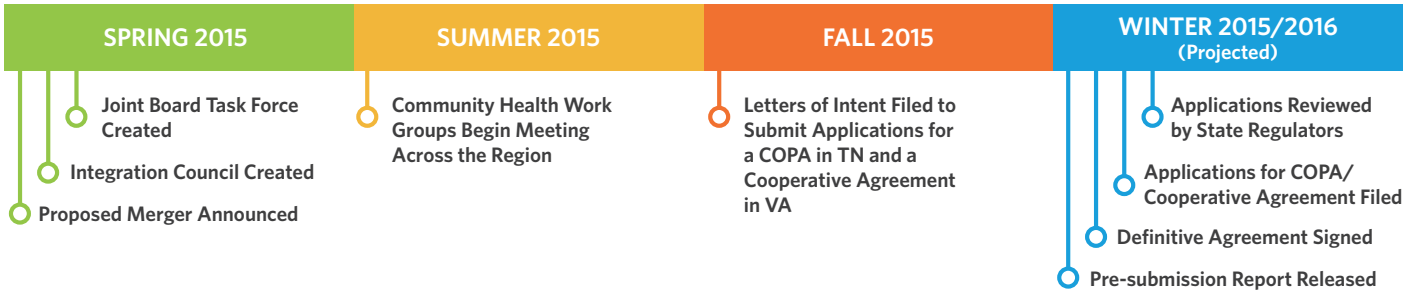
Learn more about our community commitments in a report we've developed as part of the regulatory approval process. View the report and provide feedback at: **BecomingBetterTogether.org**

The Path We're Pursuing

In April 2015, Wellmont Health System and Mountain States Health Alliance began to explore how health care in our region could look if we joined together. We had a promising vision, but we wanted to learn more from our friends, neighbors and the community to understand how we could best serve you.

We've met with thousands of people – in communities we serve both large and small – to answer questions, talk about how to best tackle our region's critical health care issues and discuss our commitment to keeping care affordable and accessible.

That work continues today, and we're making excellent progress toward bringing our organizations together. Here is a brief snapshot of our efforts:



The path we are pursuing is an innovative model unlike traditional mergers so common among hospitals and providers today. Here is how our path is different:

Our Path

- **State oversight.** Through a COPA/cooperative agreement, the proposed organization must be approved by both states, and then be actively supervised to ensure it benefits the community by providing affordable, accessible, cost-efficient and high-quality care for years to come.
- **A health system designed for our region.** Together we will create efficiencies, expand services, increase choices, improve access to care, and address the serious health issues that affect our region and matter most to the people we serve.

The Alternative

- **No enforceable protections for the community.** Standard "out-of-market" acquisitions of hospitals do not generally include strict enforcement mechanisms to protect consumers or ensure the community benefits.
- **No accountability.** An outside health system could be free to take merger-related savings and jobs out of our communities. That organization would face no requirement or local accountability to make the investments in community health that our region desperately needs.

We believe our proposed alternative is better. It is the only model that maintains local governance, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region and invests those dollars in the improved health of our region while also preserving local jobs.

Learn more at: BecomingBetterTogether.org

Wellmont Health System

Mountain States Health Alliance

Better Together

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Wellmont Health System | Mountain States Health Alliance

Our Vision

After more than a year of evaluating how best to navigate a challenging future for hospitals, Mountain States Health Alliance and Wellmont Health System agreed, in April of last year, to exclusively explore the creation of a new, integrated and locally governed health system to address the serious health issues facing the region.

Some issues are unique to our area, such as having the third lowest hospital wage index in the nation and the disproportionately poor health status of our regional population. Other challenges are faced by health systems throughout the region, such as increasing reimbursement cuts, the decline of inpatient volumes and more.

As a single integrated health system and major employer in our region, our new system will be able to provide the people we serve with even higher quality, more affordable care.

What We Are Creating

As a combined system, we will work to unite the resources of both systems with one common purpose — to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation.

» We will **aim to be among the best health systems in the nation,** known for outstanding clinical outcomes, superior patient experience and affordability.

» We will aspire to become one of the **most attractive health systems for physicians and team members.**

» We will **partner with physicians and clinically integrate** to derive new quality and value for the patients, businesses and payors who rely on us.

» We will achieve **long-term financial stability and sustainability** through the capture of major merger-specific cost-efficiencies, wise stewardship of resources and sound fiscal management.

» We will be actively supervised under a Certificate of Public Advantage in Tennessee and a cooperative agreement in Virginia that will include **enforceable targets for cost, quality and access and population health.**

Statements of Support

» "Eastman supports the decision to unify the systems in an effort to improve the quality and affordability of and access to health care in the region."
— CeeGee McCord, Eastman Chemical Company

» "A properly regulated environment will allow the entities to bring high quality health care to the people in our region at an affordable cost. This is a unique situation that will help ensure the future of health care in Southwest Virginia."
— Martin Kent, President and Chief Operating Officer, The United Company

» "My Chamber of Commerce represents hundreds of businesses. One important factor in having a healthy and thriving economy is having a healthy community. Mountain States Health Alliance and Wellmont Health System are working on a proposed merger. Providing affordable, high-quality health care with broad access is the vision. Health care is complicated and the regulations...will give these two organizations the ability to become a single entity with one goal; making the people in our region healthy."
— Beth Rhinehart, President and CEO, Bristol, Tennessee and Virginia Chamber of Commerce

Mountain States Health Alliance

Since 1998, Mountain States Health Alliance has been bringing the nation's best health care close to home to serve the residents of Northeast Tennessee, Southwest Virginia, Southeastern Kentucky and Western North Carolina. This not-for-profit health care organization based in Johnson City, Tenn., operates a family of 13 hospitals serving a 29-county region. Mountain States offers a large tertiary hospital with level 1 trauma center, a dedicated children's hospital, several community hospitals, two critical access hospitals, a behavioral health hospital, two long-term care facilities, home care and hospice services, retail pharmacies, a comprehensive medical management corporation, and the region's only provider-owned health insurance company. The team members, physicians and volunteers who make up Mountain States Health Alliance are committed to caring for you and earning your trust. For more information, visit **www.MountainStatesHealth.com**.

- $1 billion annual revenue
- 8,300+ full-time equivalent employees
- 400+ employed physicians and mid-level providers
- 1,717 staffed beds
- 239,606 emergency department visits
- $92,443,348 provided in community benefit
- $508 million annually in direct income for employees

Wellmont Health System

Wellmont Health System is a leading provider of health care services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive health care, wellness, and long-term care services across the region. Wellmont facilities include Holston Valley Medical Center in Kingsport, Tenn.; Bristol Regional Medical Center in Bristol, Tenn.; Mountain View Regional Medical Center in Norton, Va.; Lonesome Pine Hospital in Big Stone Gap, Va.; Hawkins County Memorial Hospital in Rogersville, Tenn.; and Hancock County Hospital in Sneedville, Tenn. For more information about Wellmont, please visit **www.Wellmont.org**.

- $773 million annual revenue
- 5,800 full-time equivalent employees
- 271 employed physicians & mid-level providers
- 781 staffed beds
- 170,331 emergency department visits
- $85,512,017 provided in community benefit
- $322 million annually in direct income for employees

Overview of Southwest Virginia Hospitals

Mountain States Hospitals

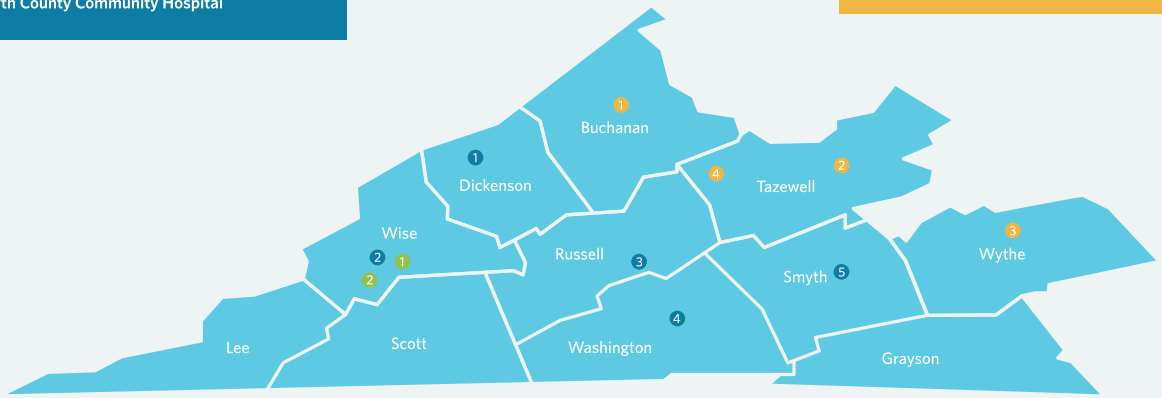
1. Dickenson Community Hospital
2. Norton Community Hospital
3. Russell County Medical Center
4. Johnston Memorial Hospital
5. Smyth County Community Hospital

Wellmont Hospitals

1. Mountain View Regional Medical Center
2. Lonesome Pine Hospital

Other Hospitals

1. Buchanan General Hospital
2. Carillion Tazewell Community Hospital
3. Wythe County Community Hospital
4. Clinch Valley Medical Center



Wellmont Health System

Mountain States Health Alliance

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Mountain States Health Alliance

Kingsport Rotary Club presentation
Wednesday, Feb. 10, 2016

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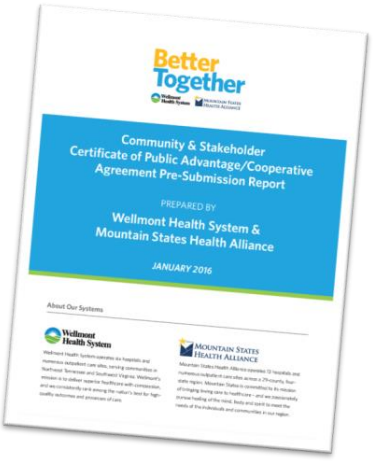
Where We Are Today

Key Milestones Timeline

Pre-Submission Report Overview

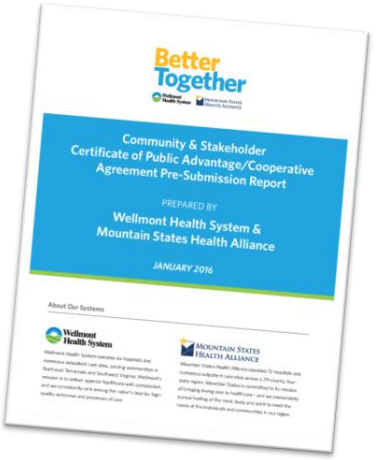
- Released January 7, 2016
- **Public report designed for the community; comments are welcome**
- To be followed by filing COPA/cooperative agreement applications

Full Report Available:
BecomingBetterTogether.org/report



Report Highlights

- Result of **more than nine months** of extensive work
- Outlines important commitments in **six key areas**
- The report also describes a **series of transformational investments** we will make as a combined system over the next 10 years to improve health in the region
  - Made possible through financial efficiencies to be achieved



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Commitments & Investments

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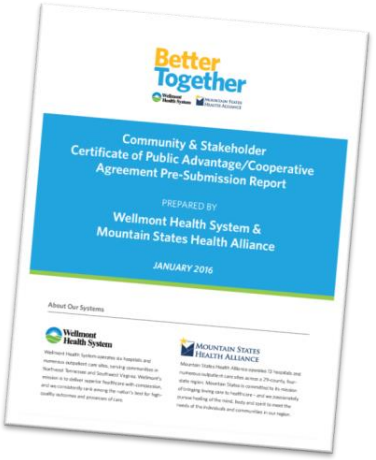
Commitments

- **Improve Community Health**
- **Enhance Health Care Services**
- **Expand Access and Choice**
- **Improve Health Care Value: Managing Quality, Cost and Services**
- **Invest in Health Research and Graduate Medical Education**
- **Attract and Retain a Strong Workforce**



Improve Community Health

Invest $75 million over 10 years in programs to address common health issues in children and adults

- Creating strong starts for children
- Living well in the community
- Promoting a drug-free community
- Decreasing avoidable hospital admission and ER use

Improve Community Health

Strong starts for children
- Childhood obesity
- Birth outcomes
- Type 1 and 2 diabetes
- Neonatal abstinence syndrome
- Third-grade reading proficiency

Living well in the community
- Diabetes
- Cardiovascular disease
- Breast, cervical, colorectal and lung cancer

Drug-free communities
- Prevent substance abuse in youth
- Prevent tobacco use in youth
- Reduce overprescription of painkillers
- Combat drug addiction through:
  - Crisis management
  - Residential treatment
  - Community-based support

Connect high-need, high-cost uninsured individuals to care
- Intensive case management
- Primary care
- Behavioral health crisis management
- Residential addiction treatment
- Intensive outpatient treatment services

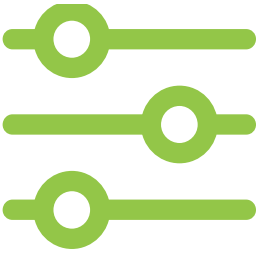
Enhance Health Care Services

Invest $140 million over 10 years in needed specialty services

- Expand residential and outpatient addiction recovery programs and community-based mental health services
  - Mobile crisis management
  - Intensive outpatient services
  - Addiction resources for adults and children
- Recruit and retain pediatric subspecialists in accordance with Niswonger Children's Hospital physician needs assessment
- Develop dedicated emergency facilities for children in Kingsport and Bristol and deploy pediatric telemedicine to rural communities
- Develop a plan to meet physician staffing needs in underserved and rural areas

Expand Access and Choice

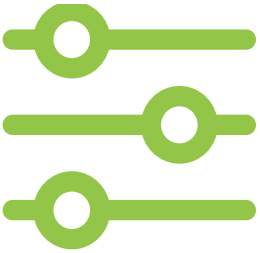
- All hospitals to remain operational as clinical and healthcare institutions for at least five years
- Maintain three full-service tertiary hospitals in Johnson City, Kingsport and Bristol
- Repurpose some current facilities to develop and enhance access to needed services
- Ensure physicians are able to practice where they choose and patients are able to seek care where they choose



Expand Access and Choice

The new health system will value a robust and successful independent physician community.

- Work with the independent physician community to build an array of service offerings
- Maintain open medical staffs at all facilities, with possible exception of hospital-based physicians
- Not require independent physicians to practice exclusively at the new health system's hospitals
- Not take steps to prohibit independent physicians from participating in health plans of their choice



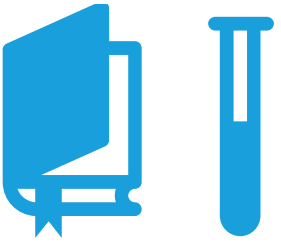
Improve Health Care Value

- Reduce the pace of health care cost growth by placing **limits on negotiated rates with insurers**
- **Invest approximately $150 million** over 10 years to facilitate electronic health information exchange and develop a common electronic health record platform
- Develop a regionwide clinical services network, collaborating to improve health outcomes
- Work in good faith with insurers to protect consumers' network access

Expand Health Research & Graduate Medical Education

The new health system will invest $85 million over 10 years to support academics and research

- Work with partners in TN and VA to develop and grow academic and research opportunities
- Support post-graduate health care training
- Increase residency slots
- Create new specialty fellowship opportunities
- Strengthen the pipeline and preparation of health professionals



Attract and Retain a Strong Workforce

- Continue to provide competitive pay and benefits
- Provide credit for accrued vacation and sick leave
- Honor prior service credit for eligibility and vesting under employee benefit plans maintained by each organization
- Combine the best of each organization's career development opportunities

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The Path We're Pursuing

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The Path We're Pursuing

Our Path

State oversight.

Through a COPA/cooperative agreement, the proposed organization must be approved by both states, and then be actively supervised to ensure it benefits the community by providing affordable, accessible, cost-efficient and high-quality care for years to come.

The Alternative

No enforceable protections for the community.

Standard "out-of-market" acquisitions of hospitals do not generally include strict enforcement mechanisms to protect consumers or ensure the community benefits.

The Path We're Pursuing

Our Path

A health system designed for our region.

Together, we will create efficiencies, expand services, increase choices, improve access to care, and address the serious health issues that affect our region and matter most to the people we serve.

The Alternative

No accountability.

An outside health system could be free to take merger-related savings and jobs out of our communities. That organization would face no requirement or local accountability to make the investments in community health that our region so desperately needs.

We believe our proposed alternative is better.
It is the only model that maintains local governance, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region and invests those dollars in the improved health of the people we serve while also preserving local jobs.

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Next Steps

- Expect to announce signing a **Definitive Agreement** and **filing COPA/cooperative agreement applications** in the coming weeks.
- **Working with officials in both states** to ensure applications are deemed complete; review period will likely extend throughout 2016.

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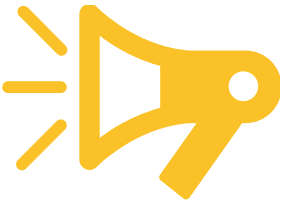
Keeping You Informed

- Committed to sharing updates
  - Visit **BecomingBetterTogether.org** for the latest news, FAQs, resources and more
  - Ongoing newsletters/internal updates
- Send general questions and comments to: **info@BecomingBetterTogether.org**
- Visit **BecomingBetterTogether.org/report** to review and provide feedback on the pre-submission report



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Questions?

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Record of Community Stakeholder and Consumer Views

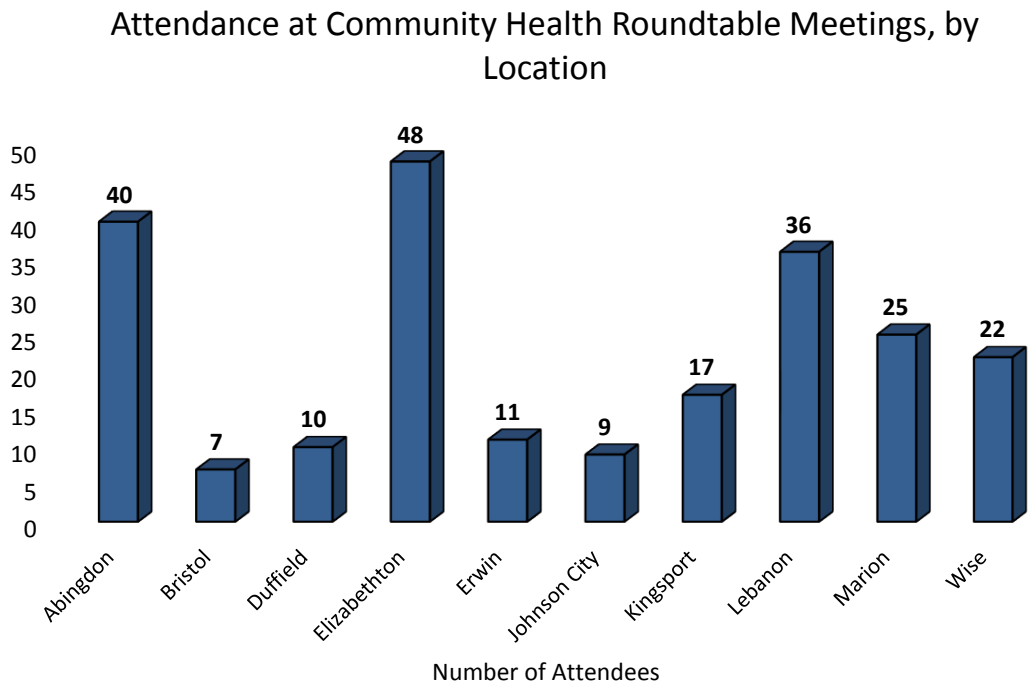
of the Proposed Cooperative Agreement

ATTACHMENT E

Roundtable Summary Reports


need
health
education
people
community
services
care
lack
drug
food
abuse
mental
access
resources
programs
nutrition
school
schools
healthy
transportation
children
family
treatment
better
substance
needs
drugs
public
kids
medical
help
families
change
healthcare
get
parents
increase
obesity
prevention
smoking
tobacco
physical
activity
communities
make
facilities
home
early
hospitals
problem
available
poor
classes
create
insurance
money
issues
use
work
free
areas
opportunities
support
time
young
improve
incentives
needed
healthier
elderly
area
meals
policy
choices
jobs
skills
addiction
information
providers
educate
options
know
high
program
system
rural
groups
start
walking
getting
exercise
barriers
population
behavior
stigma
gardens
centers
culture
focus
screening
local
hospital
parents
trails
back
development
state
break
etc

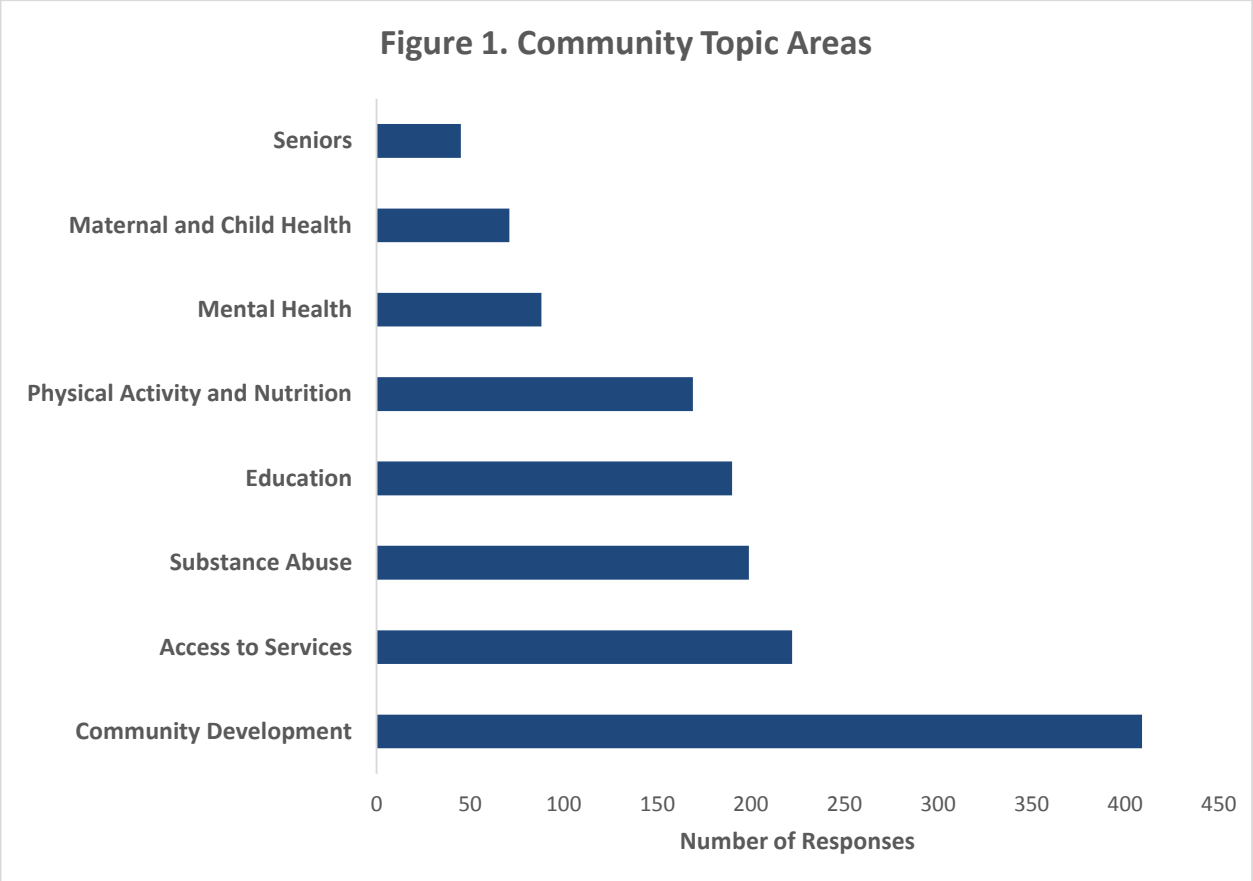
At the Community Health Roundtable meetings, there were a total of 225 attendees at ten separate events. These meetings were held from August to October, 2015. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during multiple rounds of small group discussions. For the purpose of the Community Health Roundtable meetings, participants were asked to address the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.



Main Topics of Discussion

Eight major categories of discussion emerged among the participants, within which several sub-categories were identified. The eight major categories were:

- Community Development
- Access to Services
- Substance Abuse
- Education
- Physical Activity and Nutrition
- Mental Health
- Maternal and Child Health
- Seniors



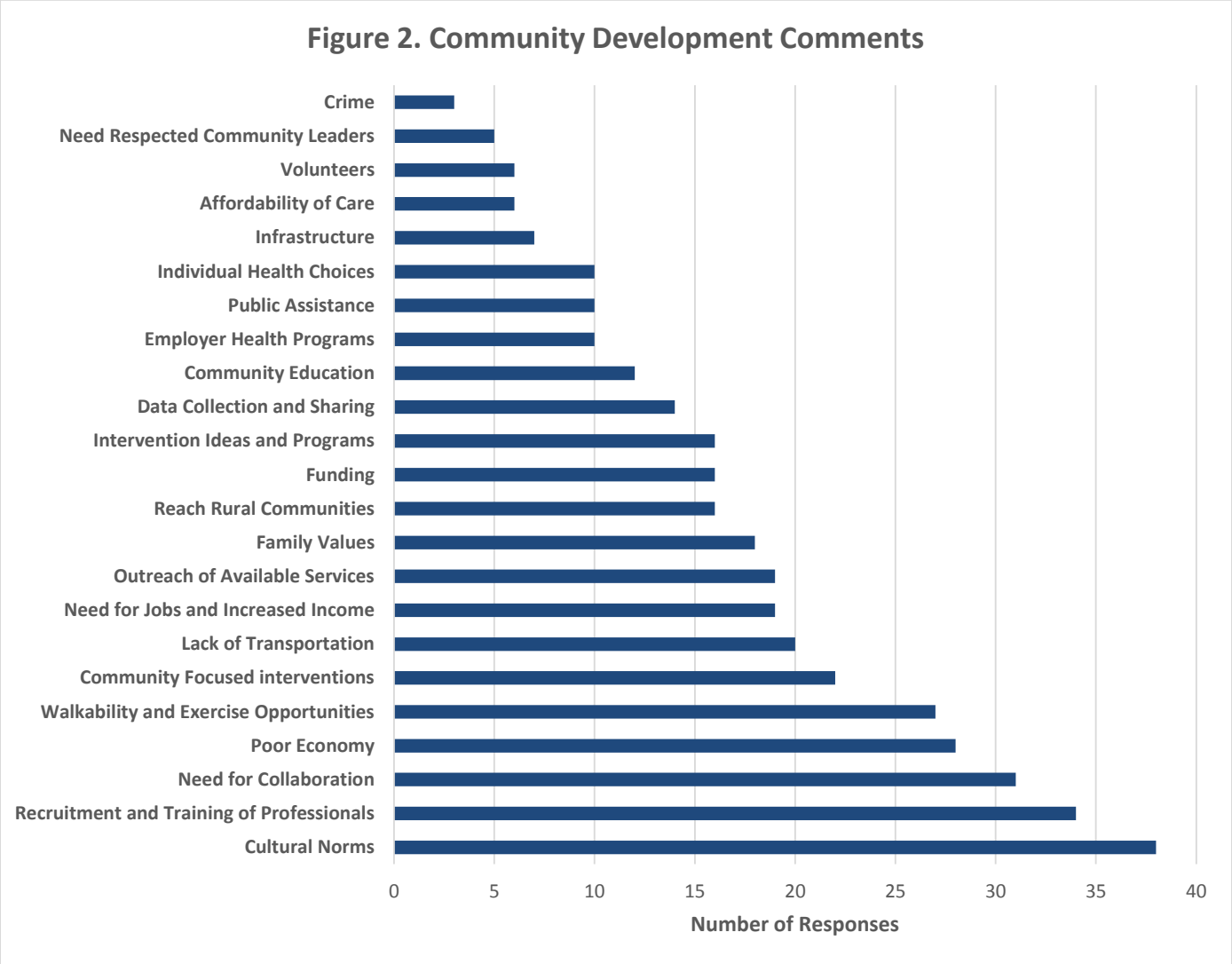
Community Development was the most talked-about topic during the discussion. Comments included such topics as:

- cultural norms
- recruitment and training of professionals
- need for collaboration among organizations
- poor economy
- need for walkability and exercise opportunities
- community-focused interventions
- lack of transportation

Other topics included the need for jobs and increased income, outreach of available services, changing family values, reaching rural communities, funding, intervention ideas and programs. Topics with a notable amount of discussion were data collection and sharing, community education, employer health programs, reliance on public assistance and individual health choices.

Consideration of these issues is important as we recruit new businesses and industry to the region while focusing on the need for economic development. Capacity issues exist with building more schools. Improved regional cooperation/collaboration is also required; we must change this mindset by changing behaviors. We need better communication to improve health literacy and the perceived personal relevance of health issues to individuals within

our community. We must prevent the abuse of public assistance, while also making sure those living in hopelessness and poverty are aware of available services and access resources appropriately. Organizations should make healthy choices more convenient and incentivize positive health behaviors. There is a driving need to have a strategic focus on what is tearing down our community and work towards a community wellness model. Figure 2 illustrates the comment distribution within the category of Community Development.



Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included:

- tobacco use and smoking
- access to resources
- community education
- the need for treatment facilities
- physician responsibility and over prescribing

Other important topics were drug court, drug abuse, prevention education for youth, providers and alternative pain management resources. Policy initiatives, family issues and prescription tracking were also widely mentioned. From

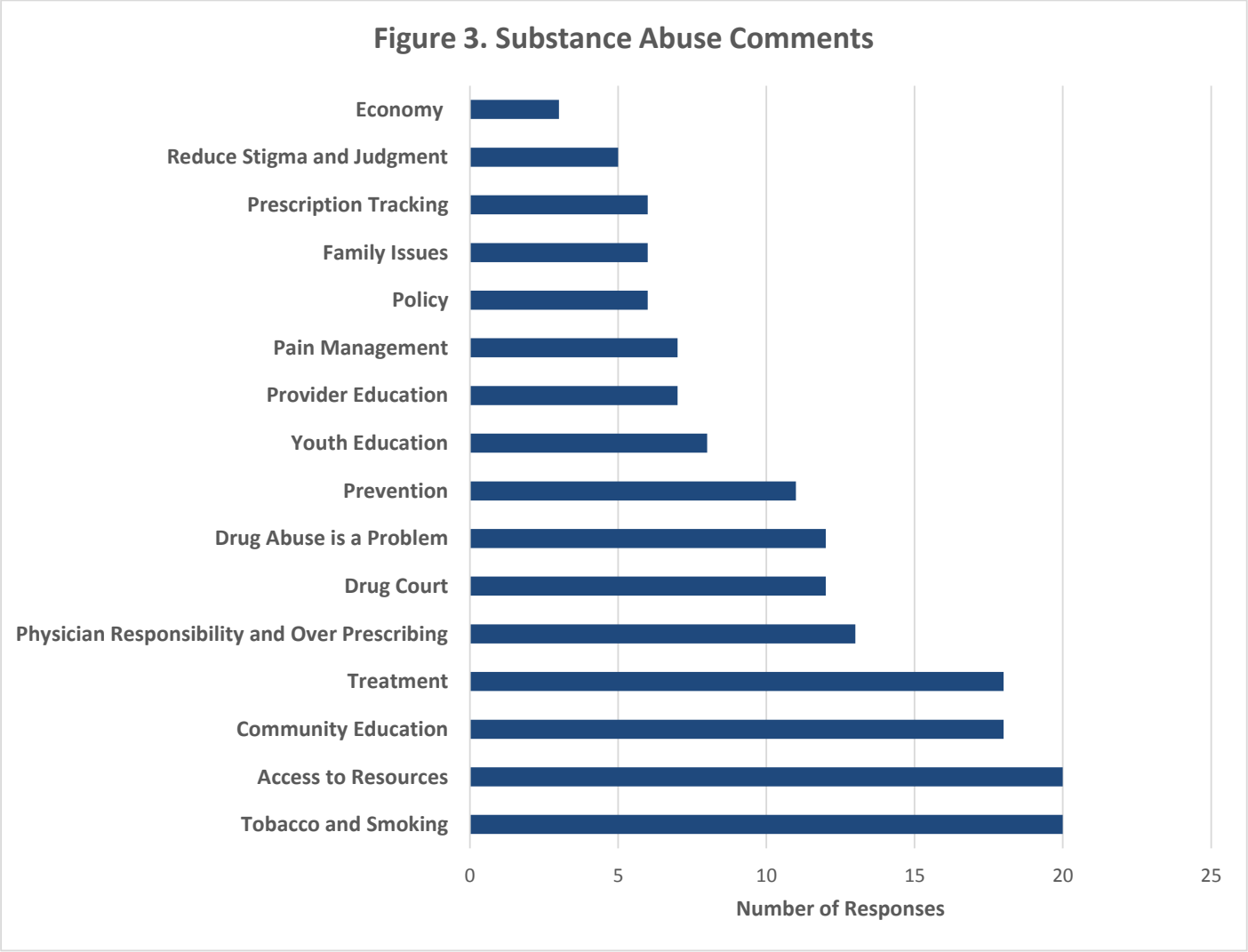
specific comments there is a need to increase education about abuse, halt the illegal production of drugs and implement stricter policies for employees who smoke.

Addiction recovery centers should be accessible and affordable, and serve people of all ages. People also must be able to locate social services that help with basic needs, such as food and housing. We must educate all young people about the risks of drug abuse; those who do abuse substances need treatment, not just jail.

Doctors write too many painkiller prescriptions because it is easier, and substance abuse has not been a priority in the past. However, both physicians and patients should try to find other approaches to managing pain in addition to (or instead of) pain medications.

To address the issue of smoking and youth tobacco use, we should focus on smoking cessation and enforce higher taxes.

Because drug abuse is intergenerational there is an urgent need for education, and to reduce the stigma around drug abuse. People must receive treatment to stop the intergenerational problem. Figure 3 shows the distribution of comments around the categories related to substance abuse.



Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic included:

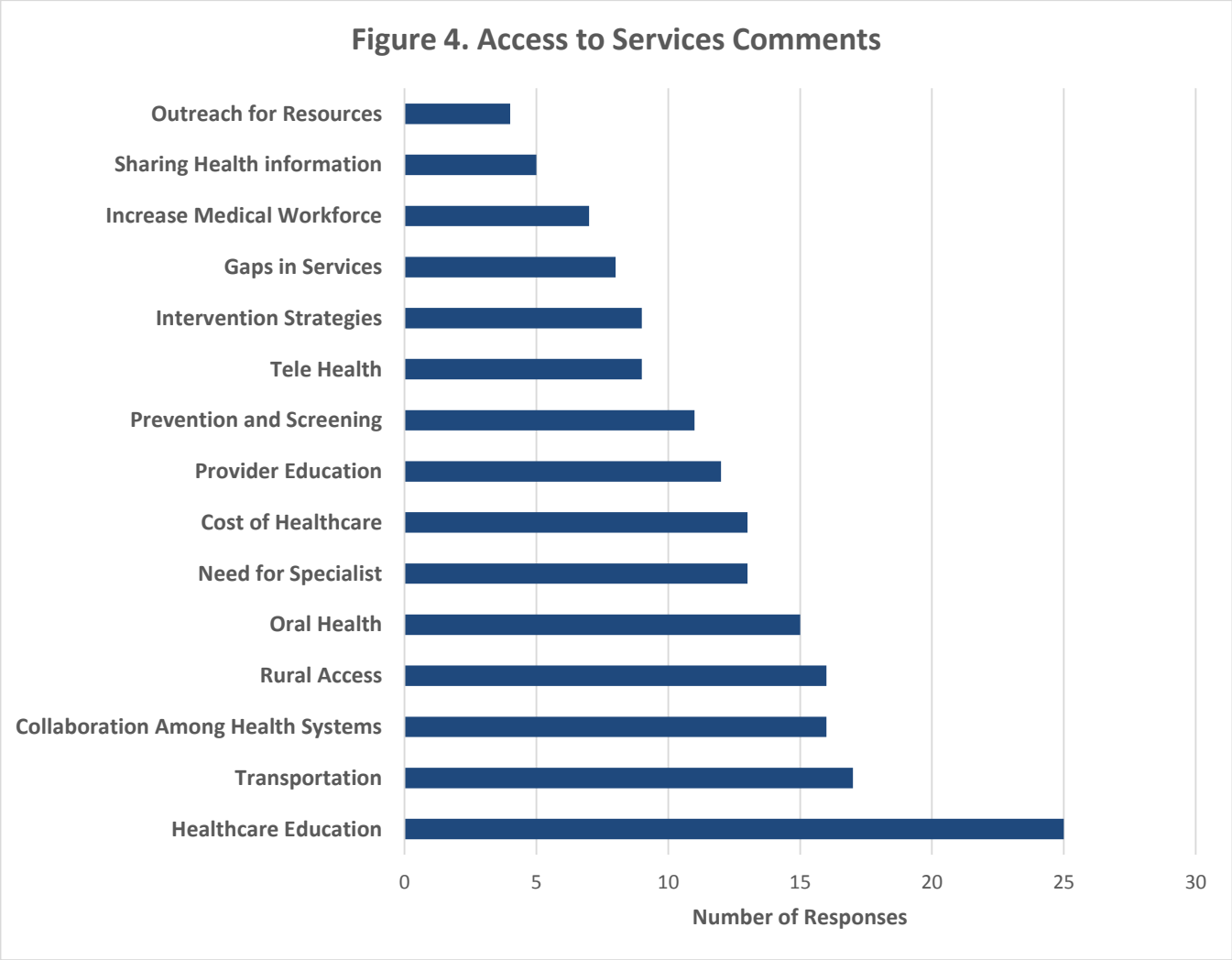
- health care education
- the need for transportation
- collaboration among health systems
- increasing rural access
- oral health services

Other topics included were the need for specialists, cost of health care, provider education, prevention and screening, telehealth use, intervention strategies, gaps in services and an increase in the medical workforce.

Particular comments focused on integrating technology, such as telehealth, and the need to collaborate with health systems, pharmacies, doctors and schools.

There is a significant need for transportation services, and to help people navigate the health care system in order to understand insurance and increase awareness of available resources. Health coaches are needed, as well as a strategy to engage people to care for their own health. It was also mentioned there is a lack of dental and specialized care in the region (although it is shown to be difficult to recruit physicians to poorer areas). Concerns were expressed about some providers being less comfortable or capable to handle some of these special conditions. Our underprivileged people flood emergency rooms but there is still trouble getting services to rural people and avoiding over-centralization.

It's important not to view short-term costs vs. long-term outcomes. Our community needs a health information exchange and to know what services are available. Figure 4 displays comment frequencies within the category of Access to Services.



Education was a broad topic that was included in a majority of topics. Participants indicated a need for education in the areas of:

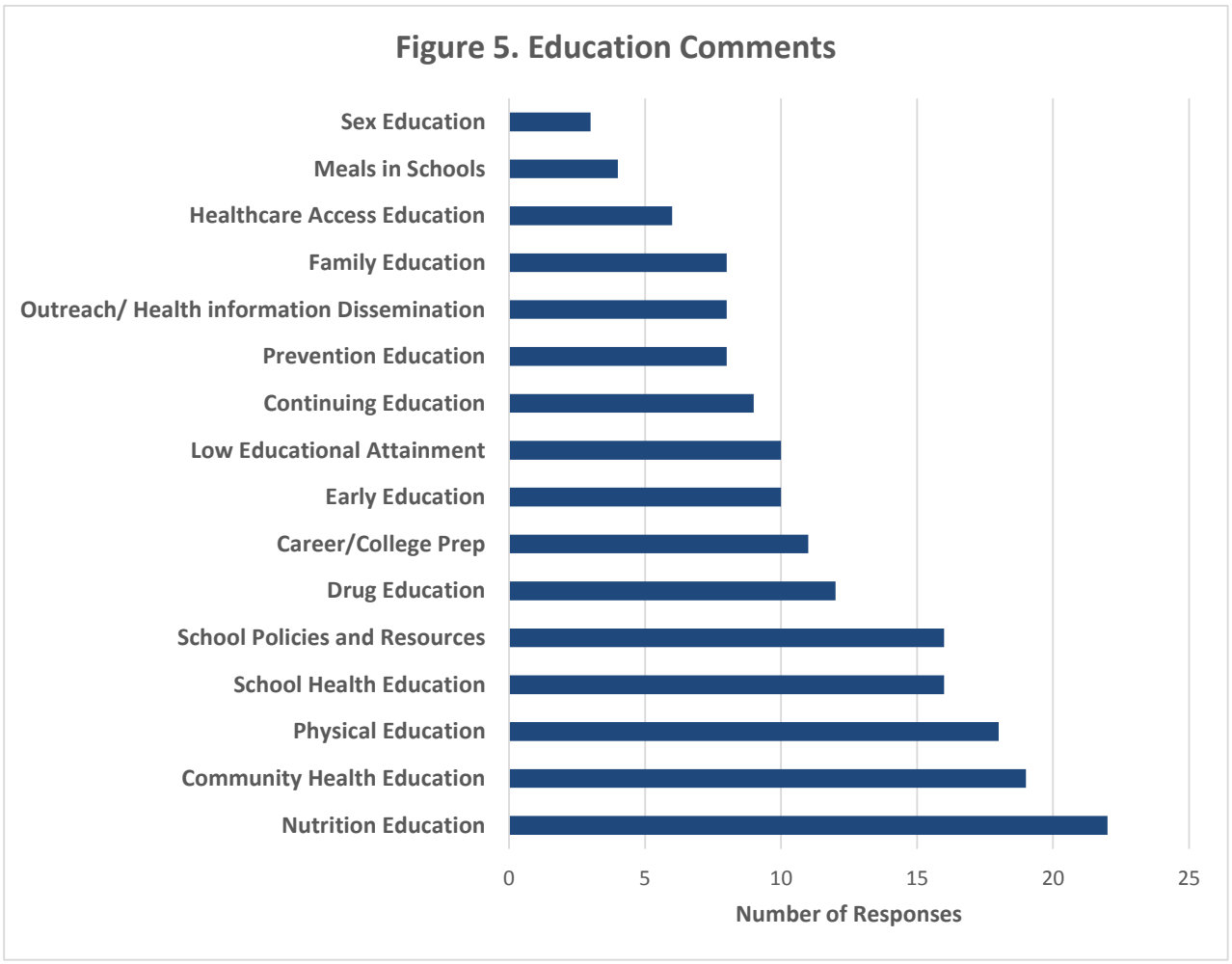
- nutrition
- drug abuse
- school health
- prevention
- family
- sex
- continuing and community health
- physical activity
- early education

Additional topics include school policies and resources, career and college prep, health care access education, outreach and information dissemination and a low educational attainment among the community. The need was identified to provide prevention education that can cut across constituencies, educate kids and break poor health habits in adults.

Other comments indicate there is a lack of health education, both formal and informal, and a need for better education about what individuals can do to help themselves.

School systems must to work together to provide a well-rounded education, and increase physical activities in the school (some have taken it out of the curriculum). Continuing education should move beyond the barriers of state/county lines and there should be an increase in career counselors in high schools to prepare students for both college and career tracks. It also was expressed that the high school drop-out rate is increasing.

Health education in public schools should be present in each grade and include parents because people do not know where to access health care. Education is the best tool for prevention. Figure 5 displays comment frequencies for the subgroups under Education.



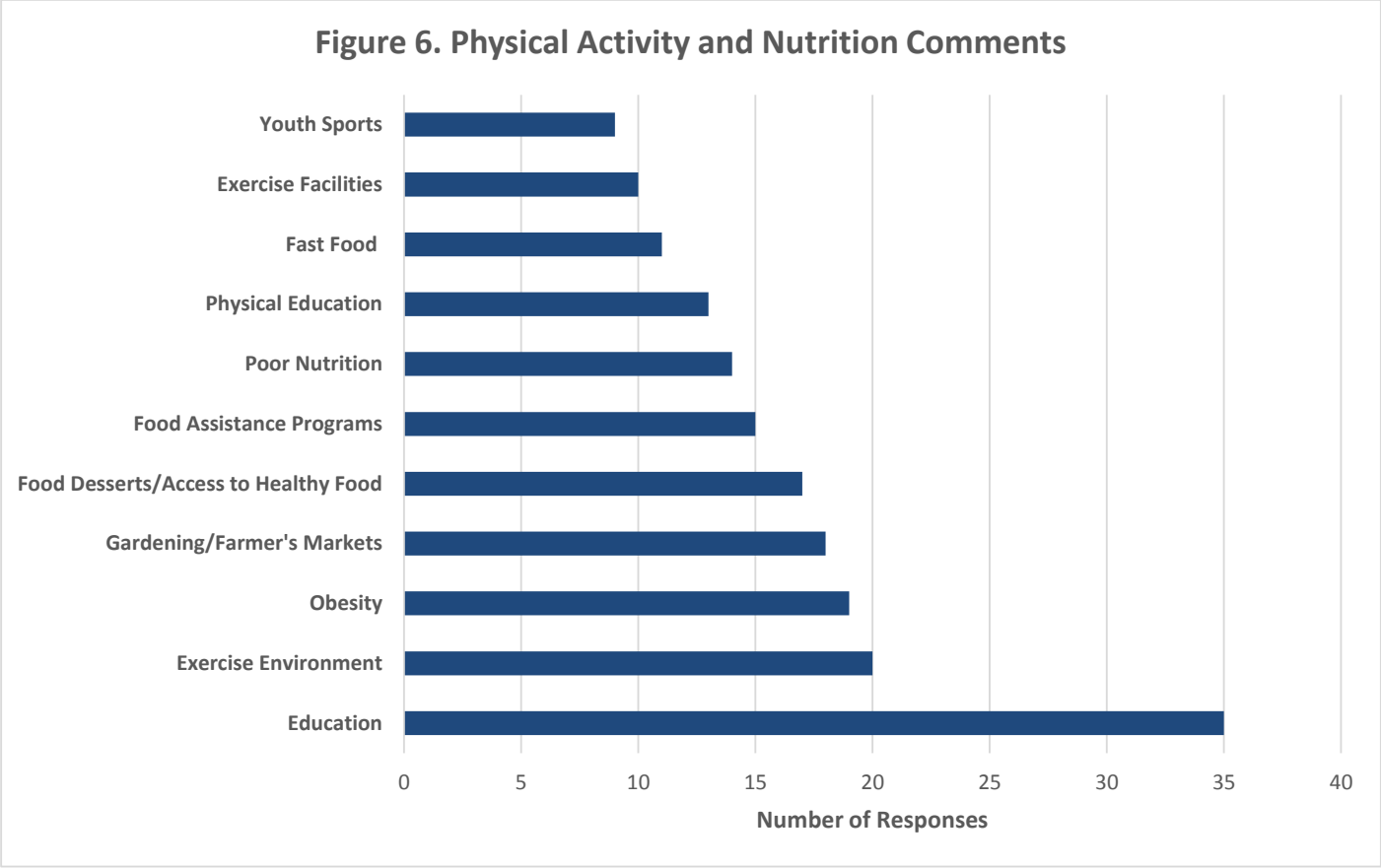
Nutrition and Physical Activity was a prominent concern among the meeting participants. Topics included:

- education
- obesity
- the need for an exercise environment
- increase gardening/farmer's markets
- food desserts/lack of access to healthy food

Other topics were food assistance programs, poor nutrition, lack of physical education, fast food availability and the need for exercise facilities and youth sports. Comments about nutrition and physical activity were focused on changing the community to build an environment to promote walking more, and addressing the lack of access to healthy foods in communities without grocery stores.

Obesity rates are increasing year by year; fast food is convenient and cheap for everyone, but is not high quality food and the serving size has increased. Physical education has been cut, or it is minimal.

The community needs nutrition and wellness classes. Food pantries help families, but there should be community support for farm-to-table restaurants and additional community gardens. There is also a lack of area fitness facilities where sports teams and clubs can give children a feeling of family. Figure 6 displays comment frequencies for Physical Activity and Nutrition subgroups.



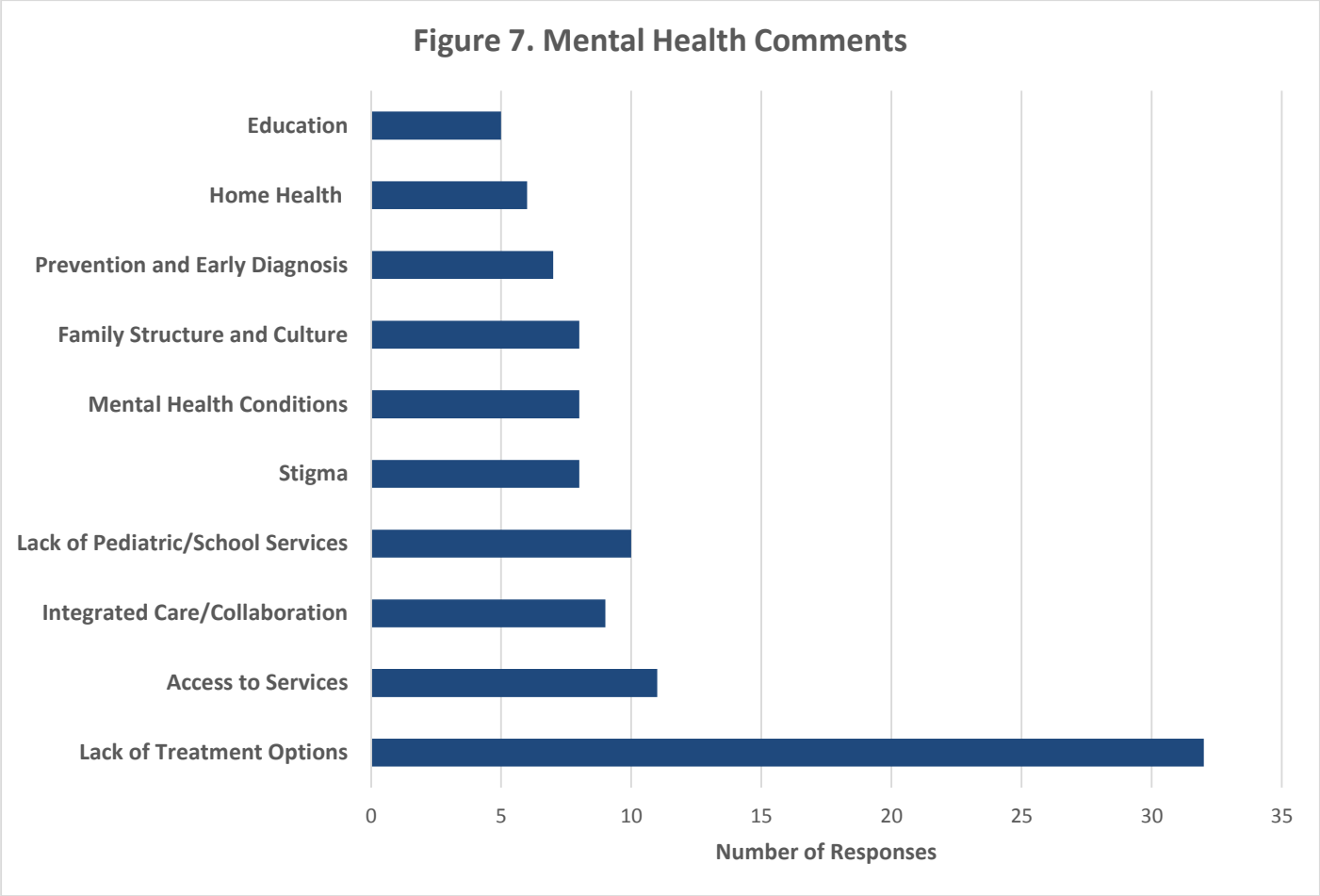
Mental Health was a concern among the meeting participants. Discussion topics include:

- lack of treatment options and facilities (the most significant topic)
- access to services
- need for integrated care/collaboration
- lack of pediatric/school services
- the stigma associated with mental health conditions

Other topics were family structure and culture, prevention and early diagnosis, home health and education. Comments about mental health noted a lack of places and resources to care for the overflow of mental health patients in hospitals. The need for mental health facilities and resources to manage self-help groups or peer supports were also mentioned.

Individuals said there are even fewer services for those most in need, and basic screenings and outreach should be in primary care offices so they can provide education and prevention services. Families who want to care for mentally ill loved ones sometimes do not have an adequate understanding of the person's needs, or support to handle or prevent incidents at home.

People are afraid to admit they struggle with mental health. We should improve education, increase access to services and enhance early-detection measures for people. Public schools should screen all children and increase mental health/behavioral services to address mental health issues for the entire family. Figure 7 shows the distribution of comments around the category of Mental Health.



Maternal and Child Health discussions were centered around:

- need for services
- community education about risky behaviors and pregnancy

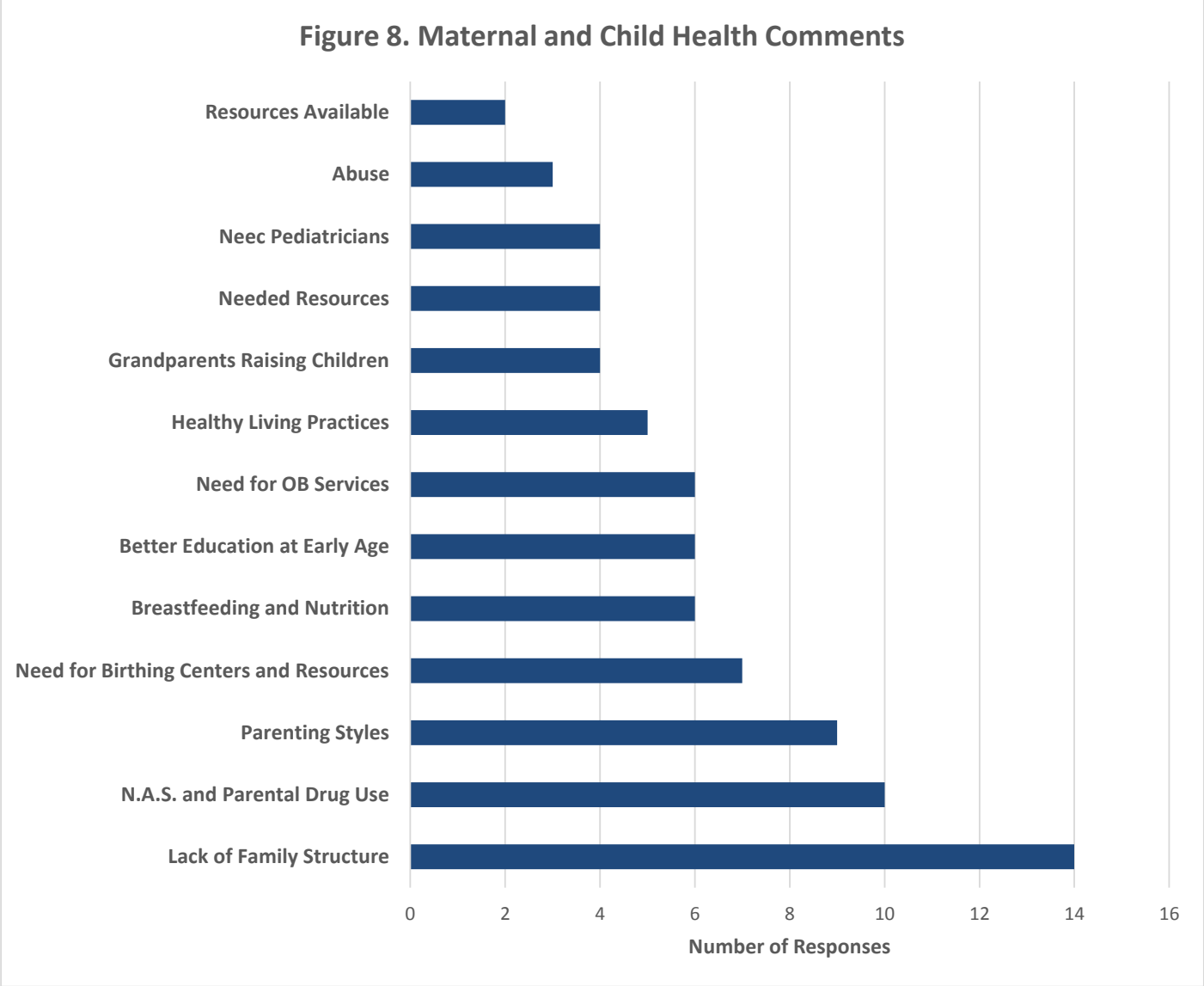
Other topics included: lack of family structure, neonatal abstinence syndrome and parental drug use, parenting styles, the need for birthing centers and resources, breastfeeding, nutrition and better education at an early age.

Additional topics were the need for OB/GYN services, healthy living practices, grandparents raising children, pediatricians, abuse and resources available.

Comments made specifically about maternal and child health expressed concern for the breakdown of families. They recommended that parents need to set more limits on kids, and noted there is a lack of guidance and support in family. There should be more community education at an early age about tobacco, physical activity, nutrition, STDs and birth control.

Mother-friendly childbirth and breastfeeding support groups with incentives were expressed as needs, as well as prenatal interventions for substance abuse and resources for special needs. Child care also should be available at

wellness centers. It was mentioned several times that there is a need for pediatricians and mobile services to schools. Figure 8 displays comment frequencies for Maternal and Child Health subtopics.



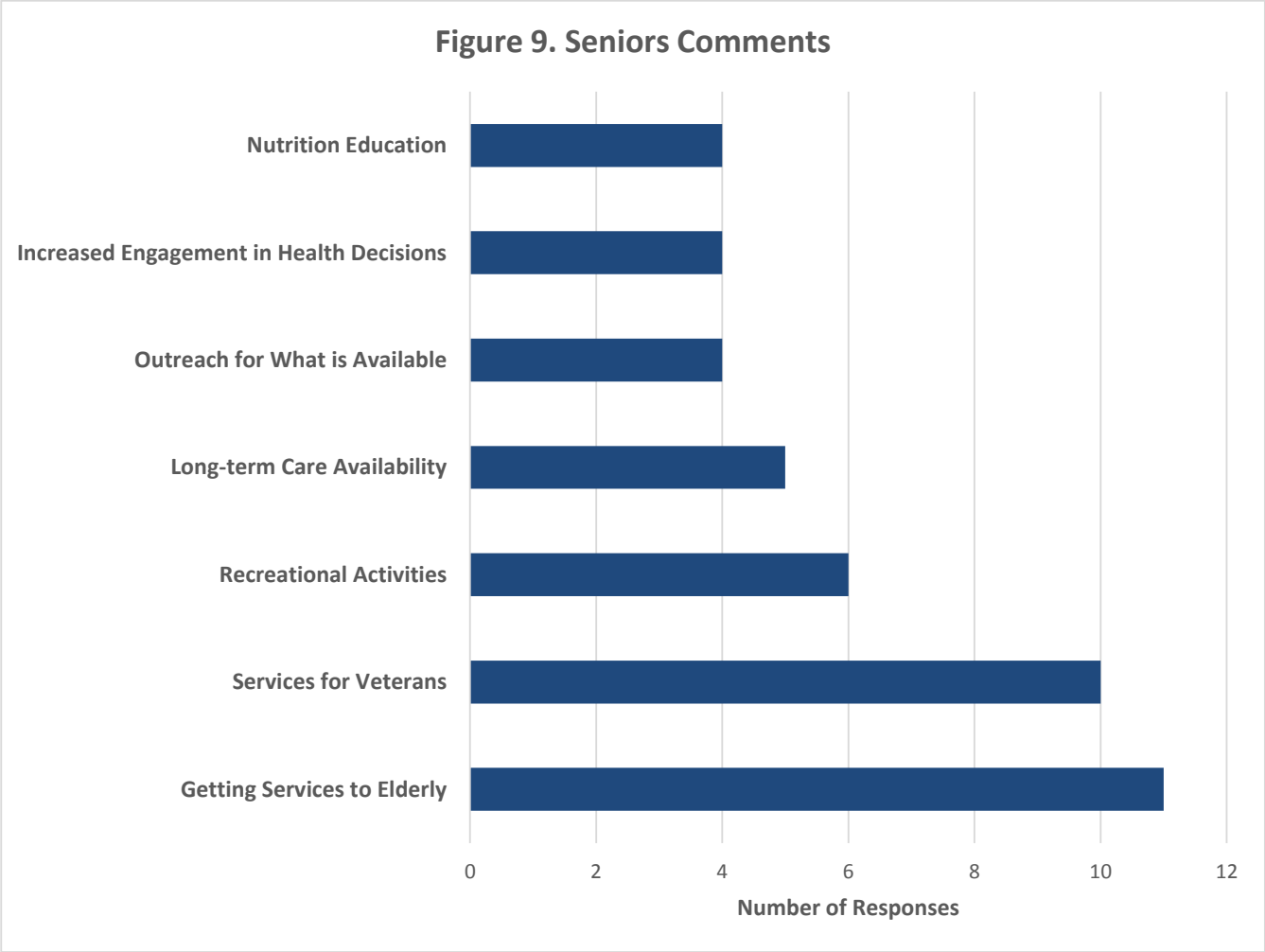
Senior issues focused on areas such as:

- availability of services for the elderly
- services for veterans
- recreational activities
- availability of long-term care

Other topics were outreach to create awareness of what is available, increased engagement in health decisions and nutrition education. Comments were made indicating a need to recognize the aging population and their needs.

Prevention care is also important for the elderly, especially shingles shots, flu vaccines and mobile immunizations. We need to go to seniors' homes to provide services and create more opportunities for physical exercise.

Our elderly population is increasing, but no new beds are opening up. Distances to facilities like the VA center are too far and there is an overall lack of availability for veterans. Figure 9 shows the distribution of comments around category of Seniors.



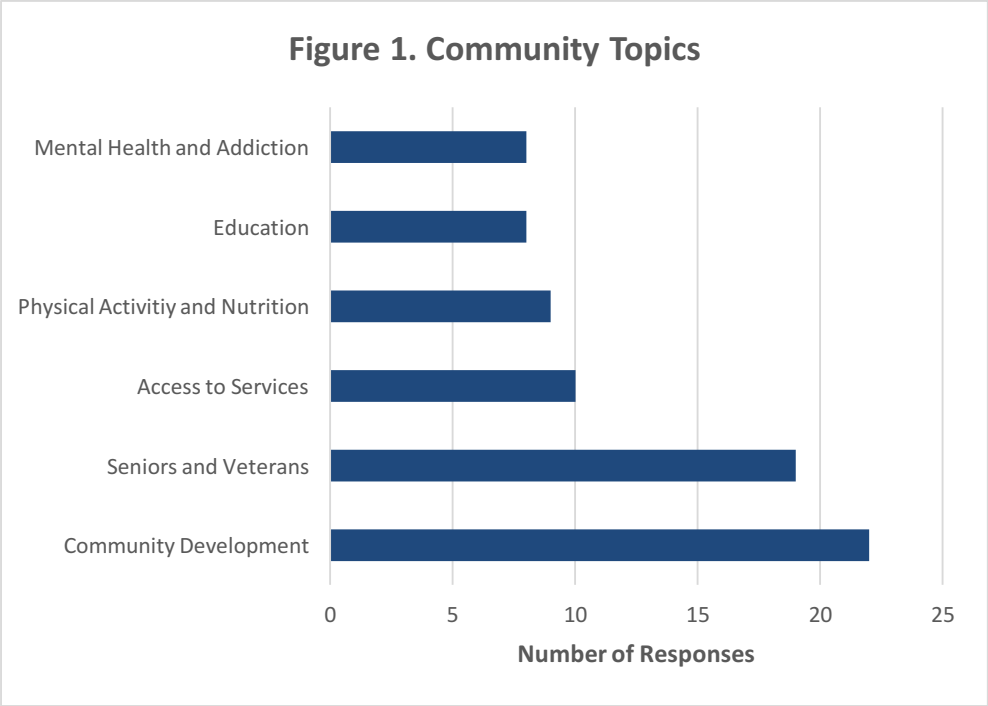
Qualitative Data Summary
Wise Community Health Roundtable Meeting
October 20th, 2015

At the Wise meeting there were 22 attendees sitting around 4 tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts", to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

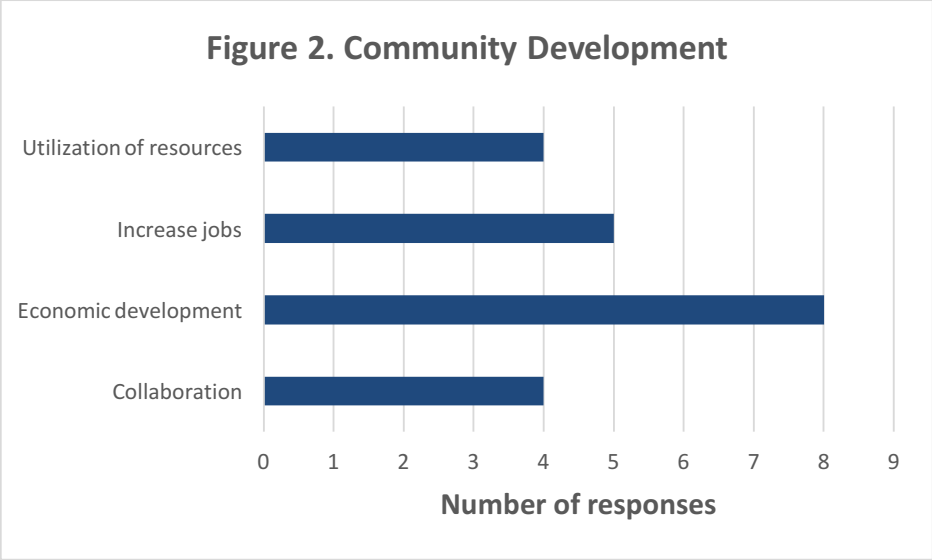
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

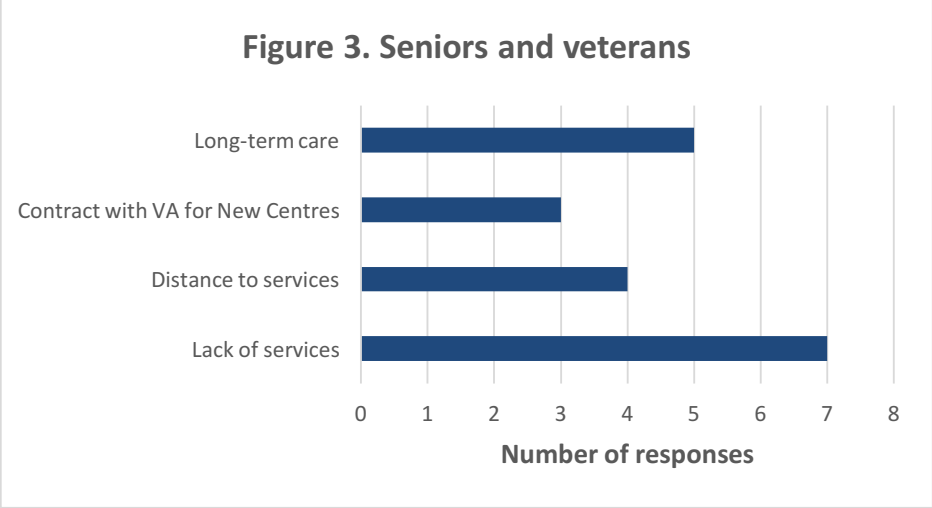
- Community Development
- Seniors and Veterans
- Access to Services
- Physical Activity and Nutrition
- Education
- Mental Health and Addiction



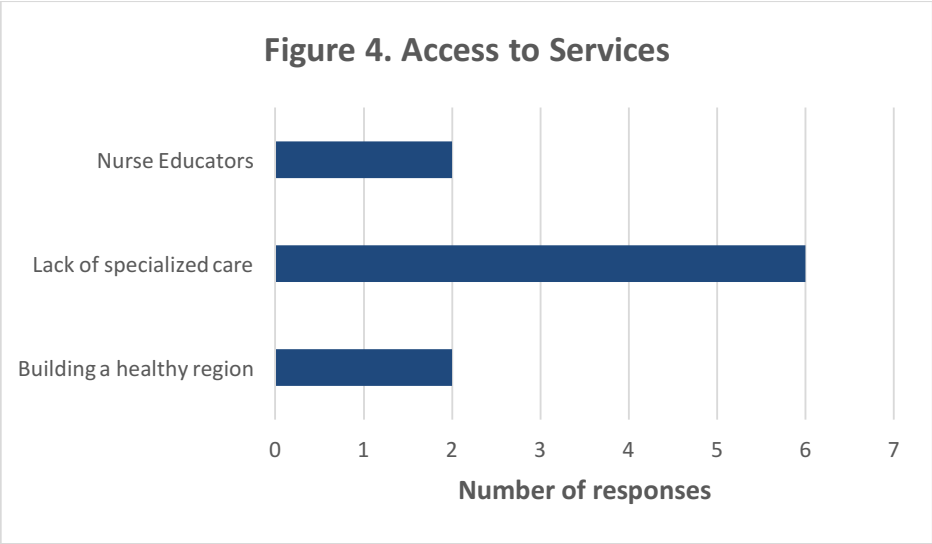
Community Development was the most talked about topic during the discussion. In order to identify specific categories within the discussion around community development, comments were broken out and considered individually. Topics under community development included utilization of resources, increase jobs, economic development and collaboration. Figure 2 illustrates the Comment distribution within this topic.



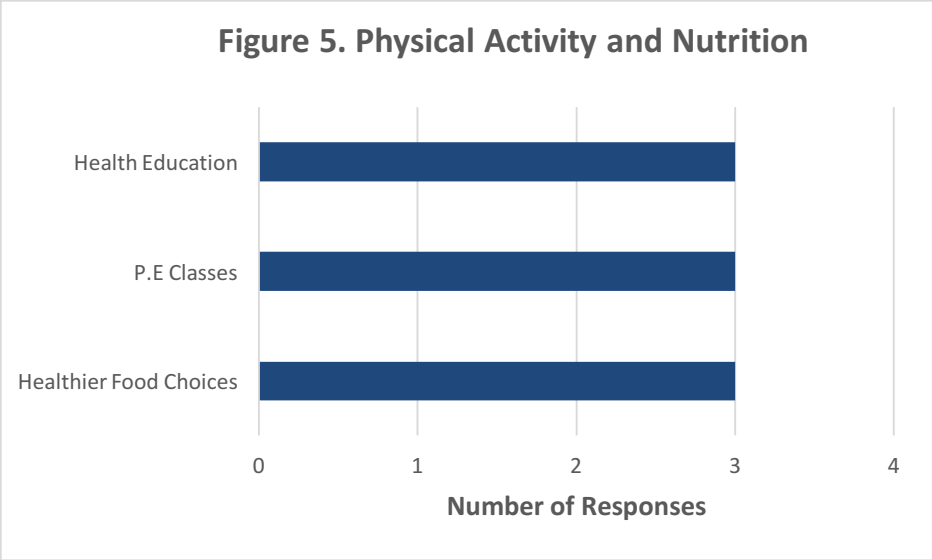
Seniors and Veterans was the second largest topic of concern among the attendees. Focus areas within this topic included distance to services, lack of services, need for long-term care and additional contracts with VA for new centers. Figure 3 shows the distribution of Comments around these categories.



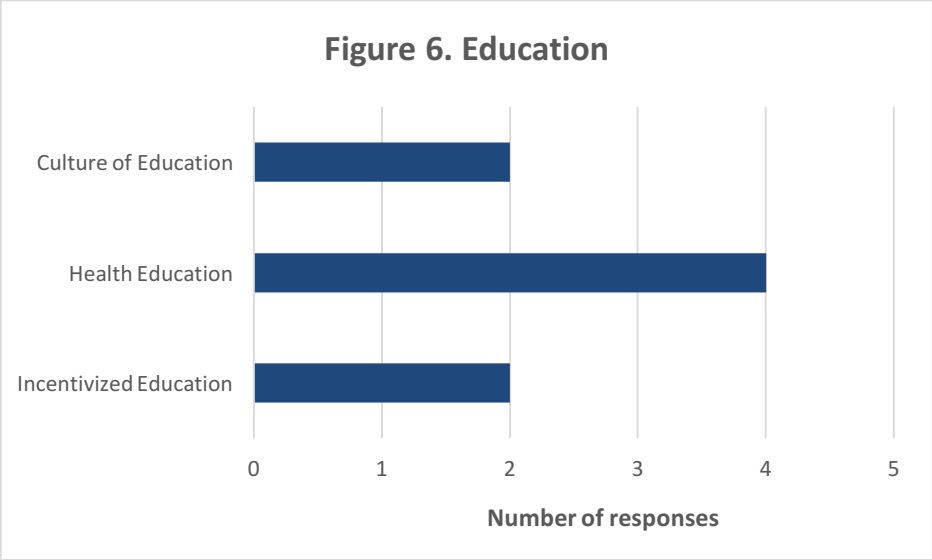
Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the need for building a healthy region, lack of specialized care and more nurse educators. Participants indicated the need for subspecialists and more physicians in the region. Figure 4 displays Comment frequencies within the subgroups.



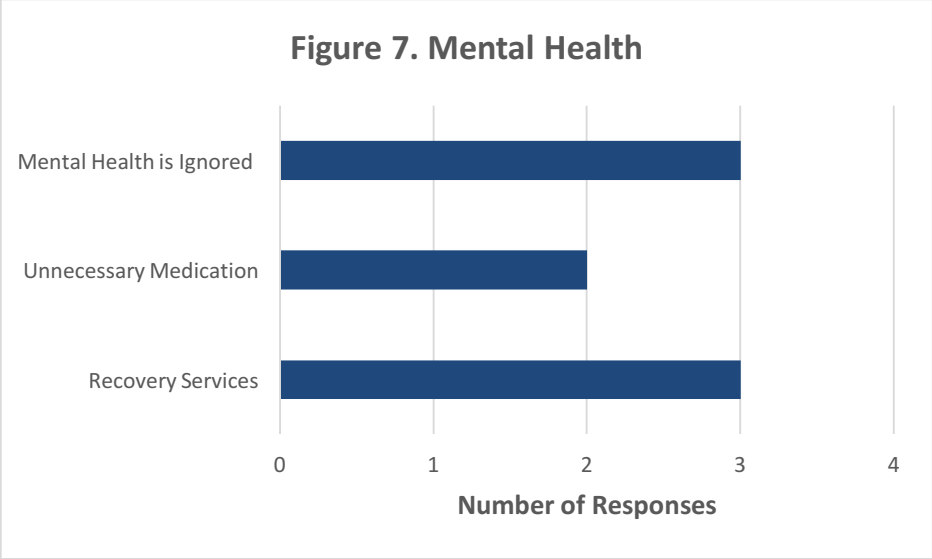
Nutrition and Physical Activity was a prominent concern among the meeting participants. Folks indicated a need for healthier food choices, P.E classes and health education. Healthier food choices, P.E classes and health education each were discussed equally. Figure 5 displays Comment frequencies for these subgroups.



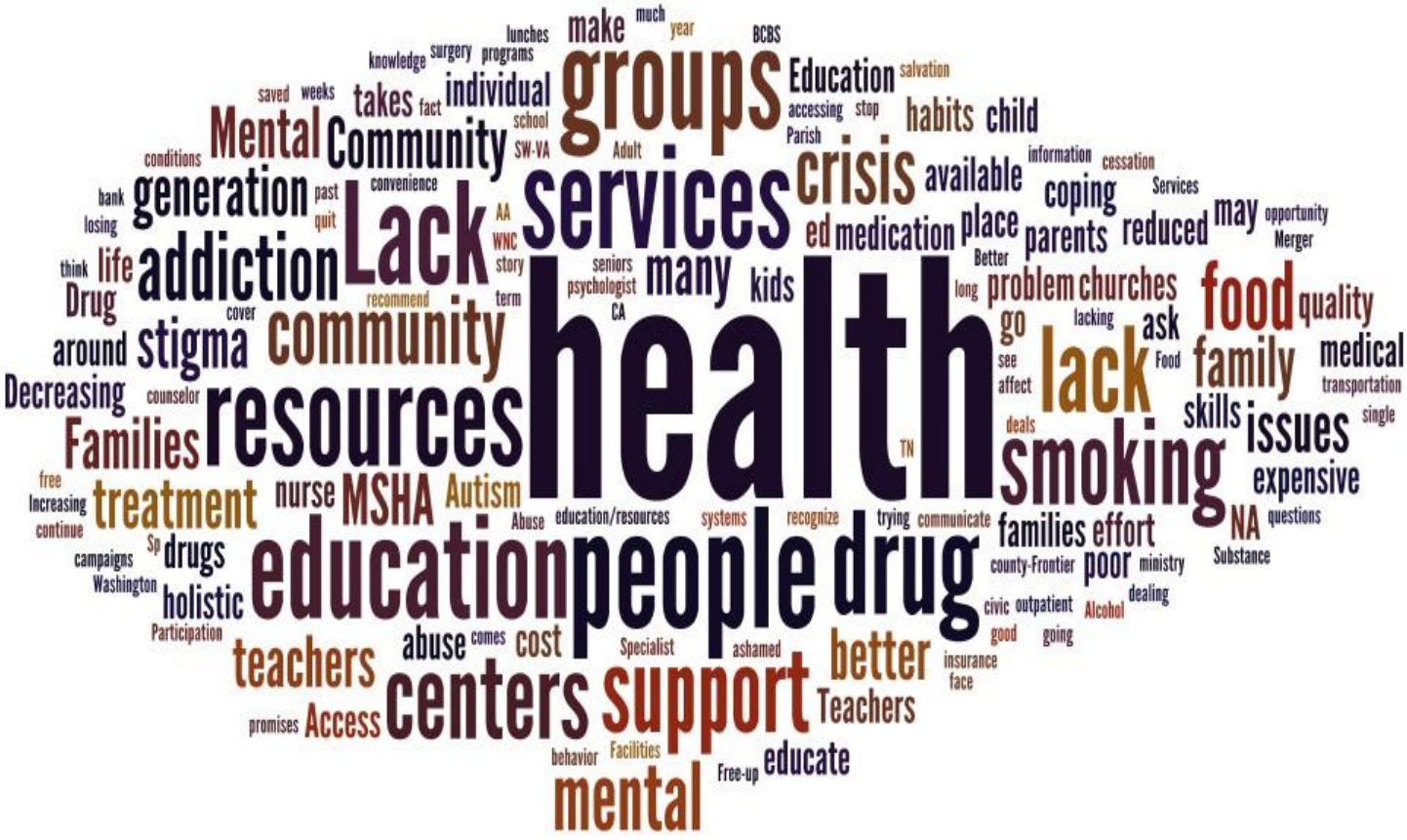
Education was a broad topic that was prevalent within every major discussion topic. Folks indicated a need for incentivized education, culture of education and increased health education. Figure 6 displays Comment frequencies for these subgroups.



Mental Health was a prominent concern among the meeting participants. Subgroups within the topic included Concerns about mental health being ignored, unnecessary education and recovery services. The need for recovery and treatment services being available and affordable to all people was mentioned. Figure 7 shows the distribution of Comments around these categories.



Qualitative Data Summary
Johnson City Community Health Roundtable meeting
October 22, 2015

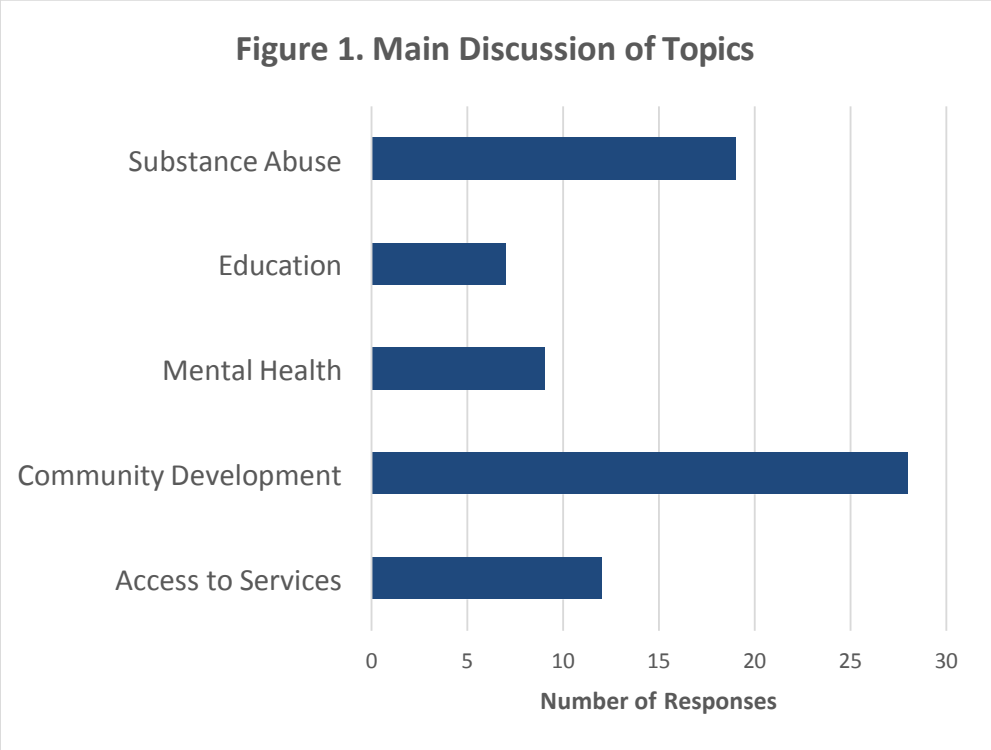


At the Johnson City meeting there were nine attendees sitting around two tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

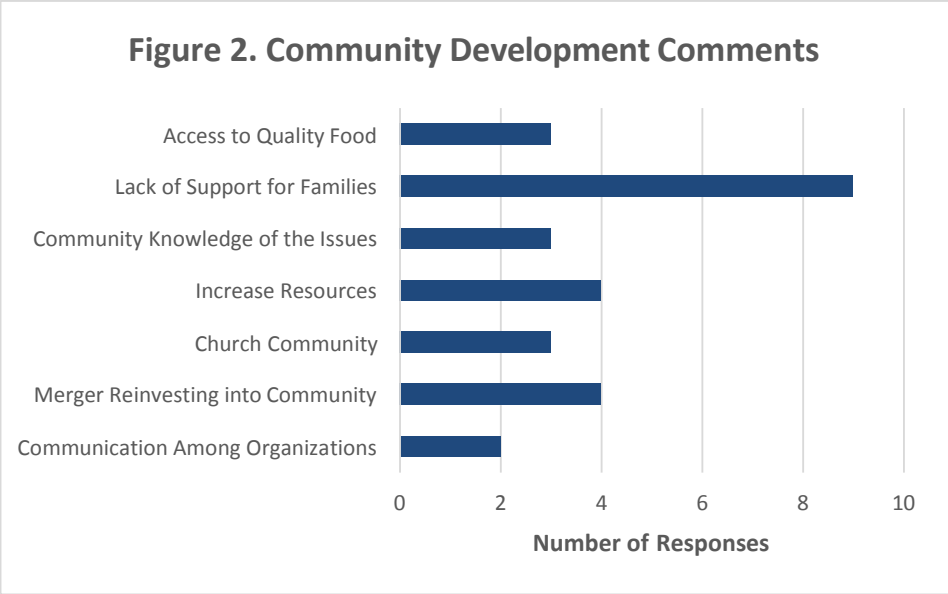
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified:

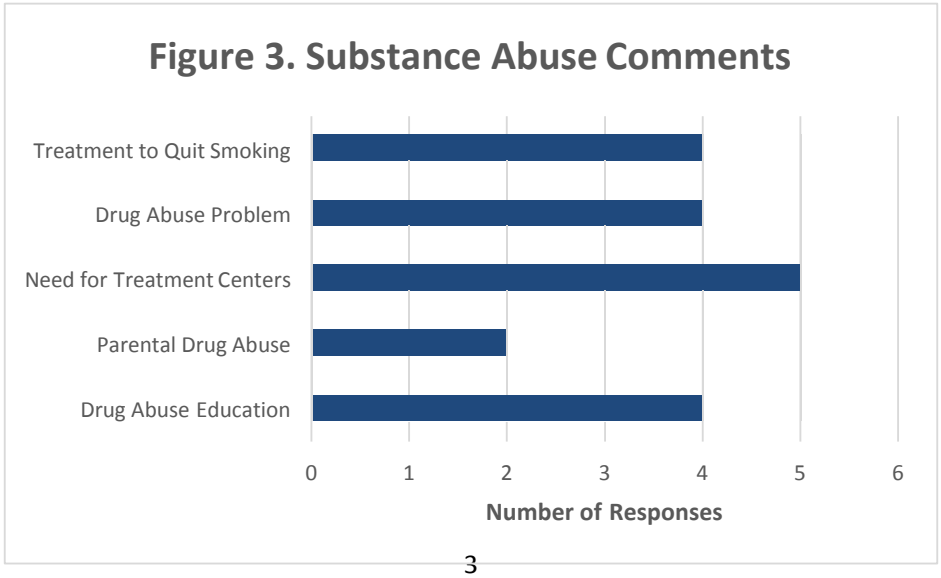
- Substance Abuse
- Education
- Mental Health
- Community Development
- Access to Services



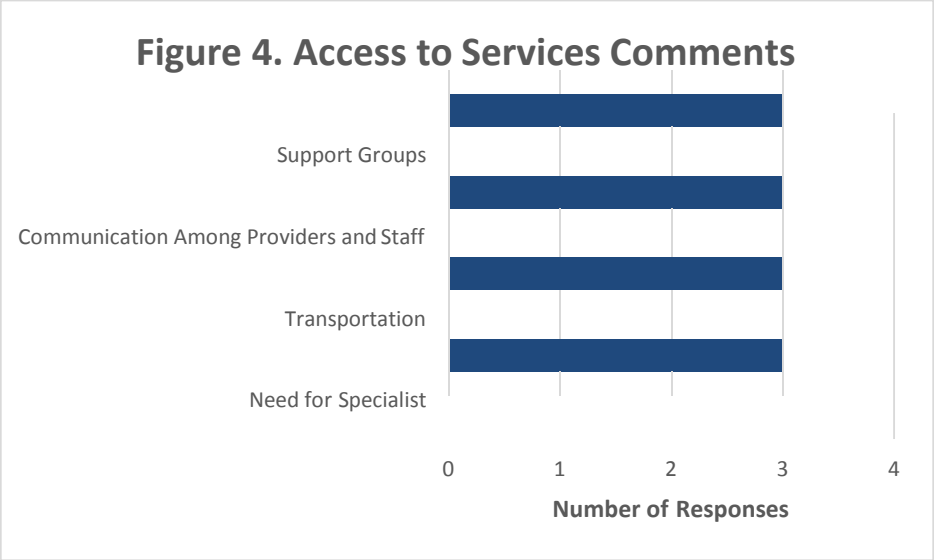
Community Development was the most talked about topic during the discussion. In order to identify specific categories within the discussion around community development, comments were broken out and considered individually. Topics under community development included access to quality food, lack of support for families, community knowledge of the issues, increasing resources, the need for church communities, concerns about the merger investing in to the community and communication among organizations. Figure 2 illustrates the comment distribution within this topic.



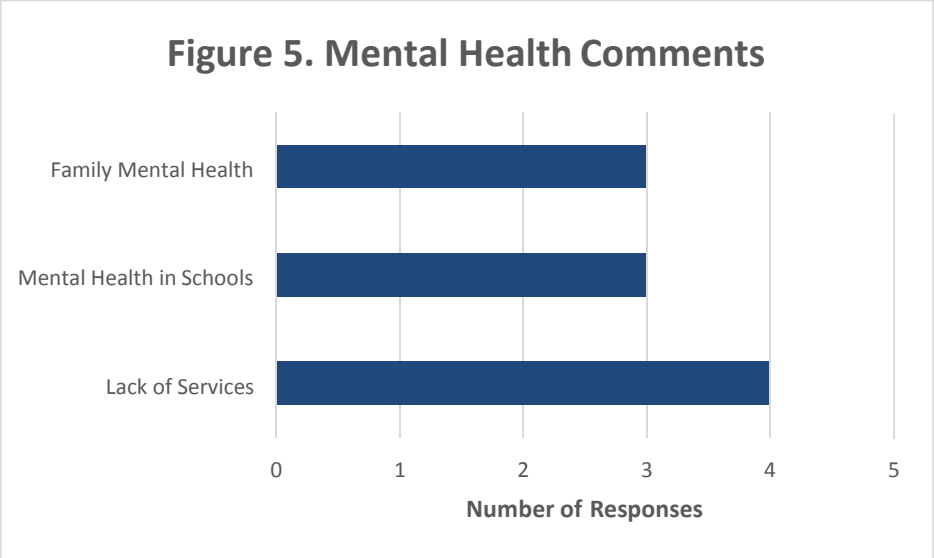
Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: the need for treatments to help quit smoking, the recognition of the drug abuse problem, need for treatment centers, parental drug abuse and the need for drug abuse education. Figure 3 shows the distribution of comments around these categories.



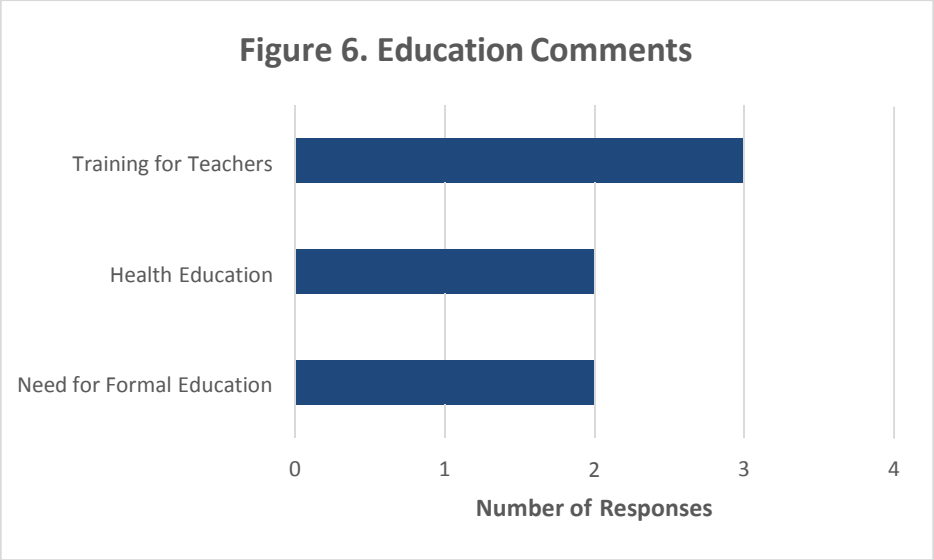
Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the need for support groups for chronic conditions, transportation, the need for specialists and communication among hospital providers and staff. Participants indicated the need for Mountain States Health Alliance to accept Blue Cross Blue Shield, and improved communication between nurses and doctors when new patients are admitted. Figure 4 displays comment frequencies within the subgroups.



Mental Health comments were considered separately from substance abuse in order to identify specific mental health needs within the community. The discussion around mental health dealt with lack of access to resources, the need for mental health services in schools and family mental health services. Many felt there was a need for education and services to be provided in schools regarding mental health. Figure 5 displays comment frequencies for this discussion topic.



Education is a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the need for teacher training, health education and the need for formal education. Participants indicated the need for teachers to be trained on health issues and medications children may be taking. Figure 6 displays comment frequencies within the subgroups.

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restaurants
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premises
menus
office
potential
cards
people
technology
therapists
screening
smart
truck
deductions
expansions
Availability
laboratory
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Typically
employers
school
store
paths
incentivizing
Poverty
reduce
Mobile
employer's
clients/employers
city
community
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programs
foods
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Incentivize
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greater
heart
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infrastructure
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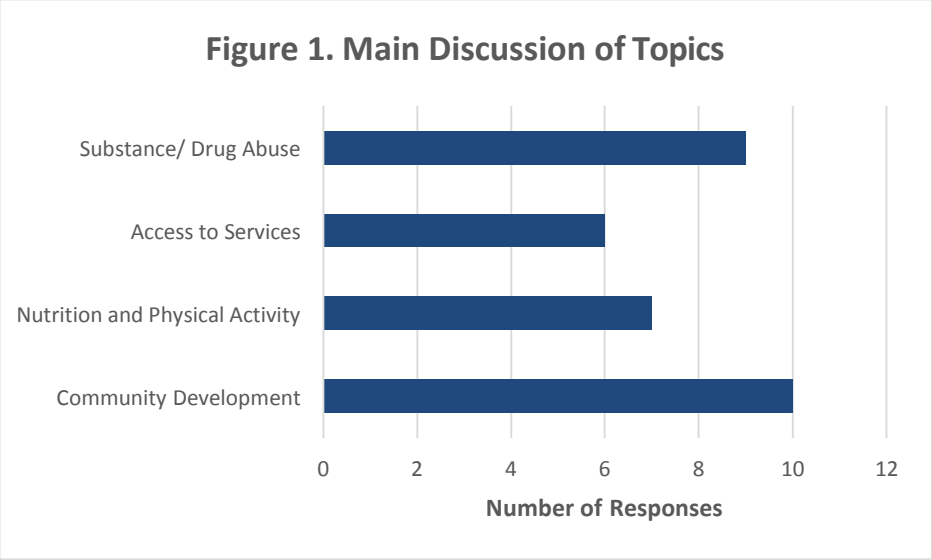
At the Bristol meeting there were seven attendees sitting around two tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

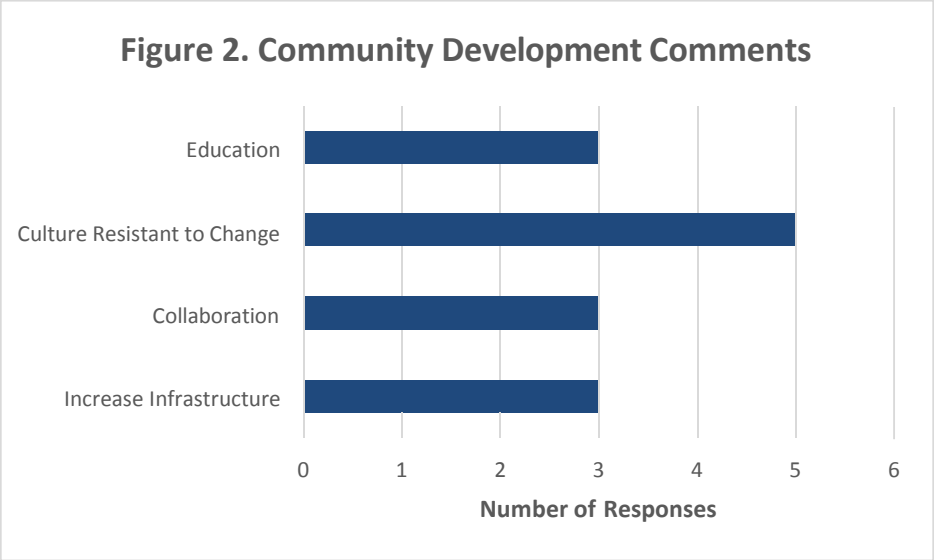
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

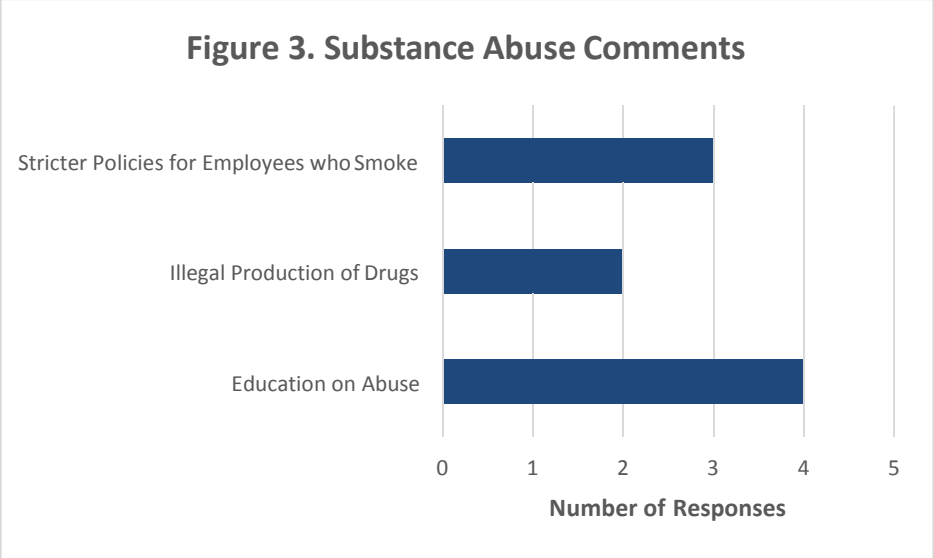
- Substance Abuse
- Nutrition and Physical Activity
- Access to Services
- Community Development



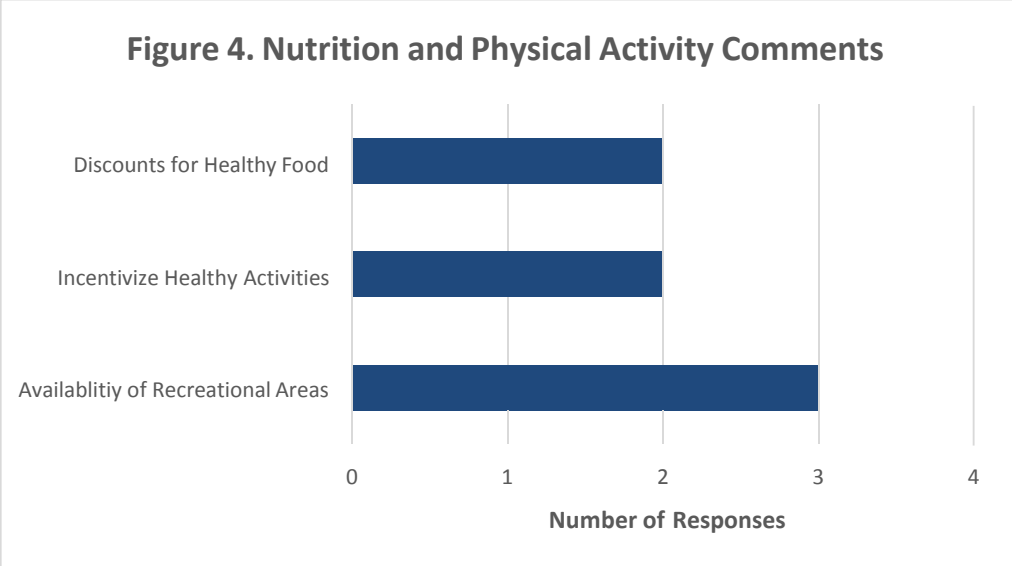
Community Development was the most talked about topic during the discussion. In order to identify specific categories within the discussion around community development, comments were broken out and considered individually. Topics under community development included the problem of culture being resistant to change, collaboration, education and increasing infrastructure. Figure 2 illustrates the comment distribution within this topic.



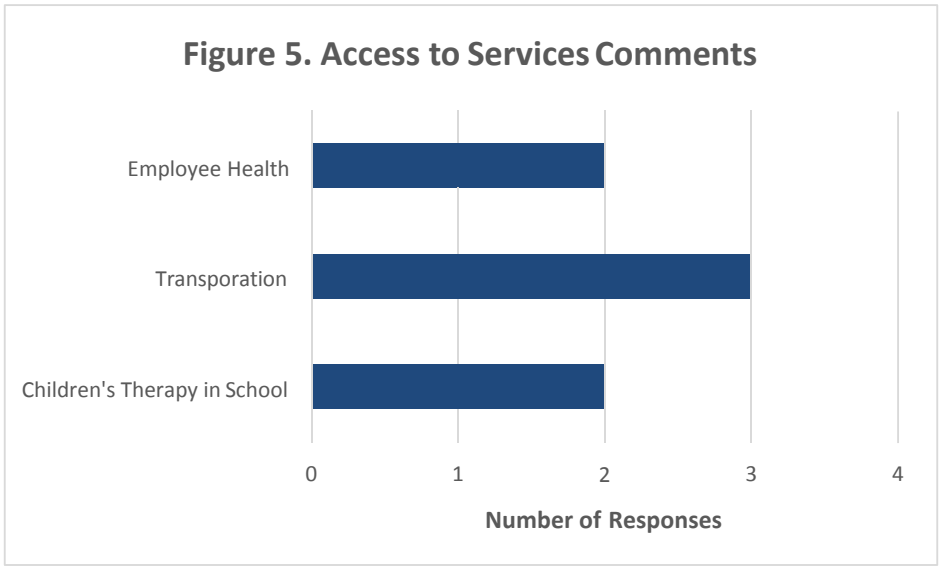
Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: increasing education about abuse, halting the illegal production of drugs and creating stricter policies for employees who smoke. Figure 3 shows the distribution of comments around these categories.



Nutrition and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for incentivizing healthy activities, increasing availability of recreational areas and providing discounts for healthy food. When discussing lack of availability of recreational areas, people mentioned the need for connecting people to the outdoors and increasing facilities for recreational activity. Figure 4 displays comment frequencies for these subgroups.



Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the need for transportation, children's therapy in schools and employee health programs. Participants indicated the need for transportation for children and for community members to receive health services. Figure 5 displays comment frequencies within the subgroups.

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Transportation
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overtime
problem
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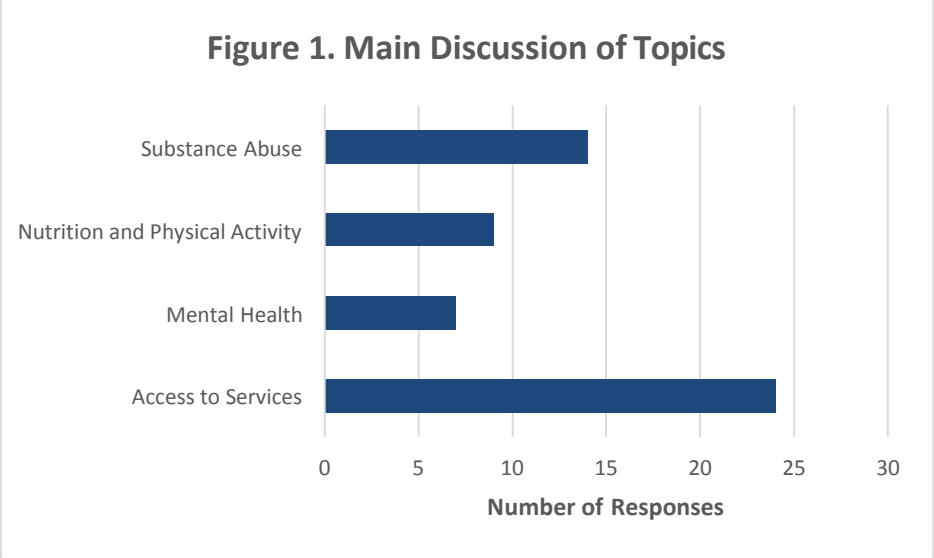
At the Duffield meeting there were ten attendees sitting around two tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

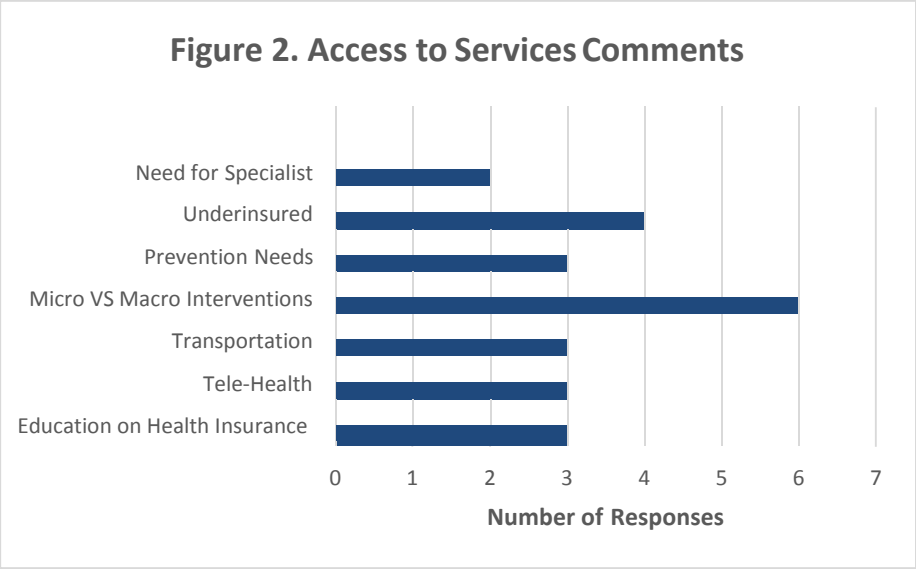
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

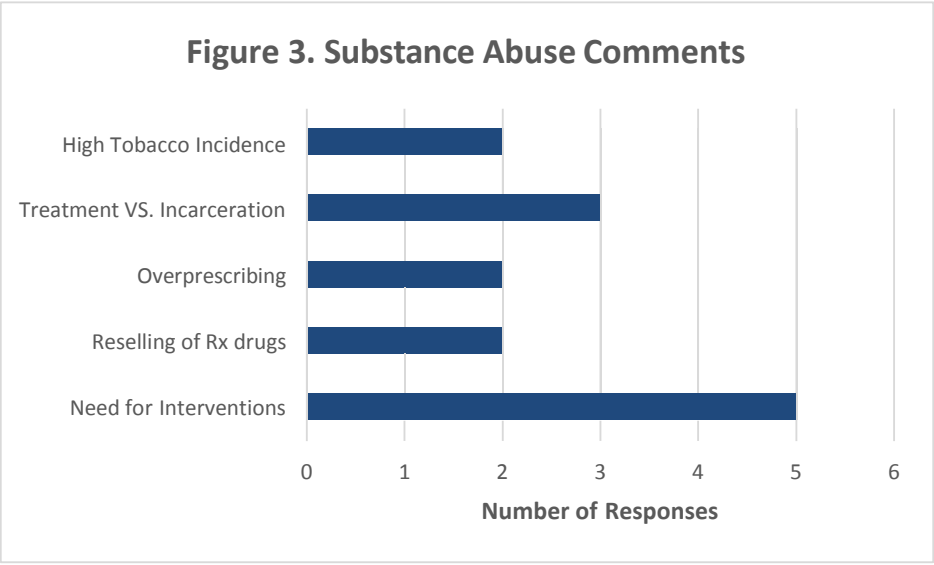
- Mental Health
- Substance Abuse
- Nutrition and Physical Activity
- Access to Services



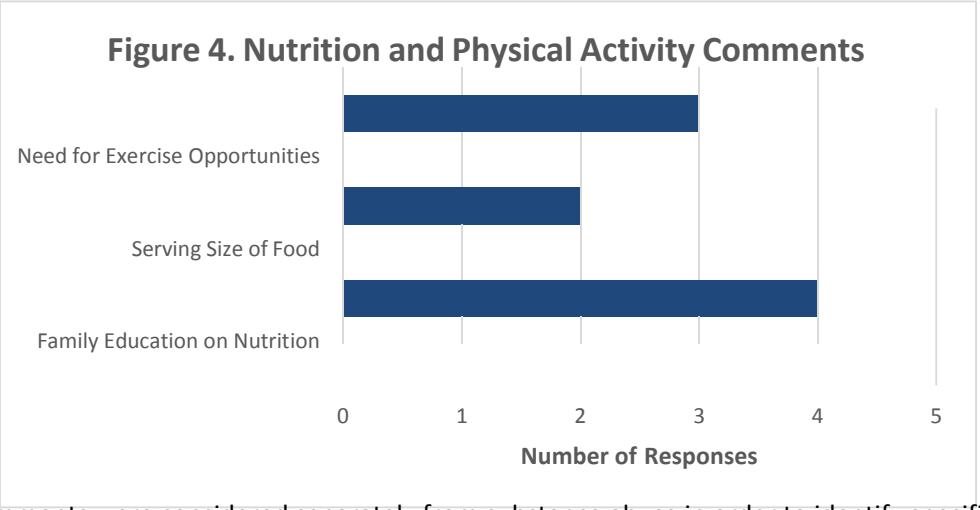
Access to Services was the most talked about topic during the discussion. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included uninsured/underinsured individuals, prevention needs, a need for more specialists, micro and macro intervention options, transportation, telehealth and education. Comments about micro and macro interventions mentioned interventions for underserved populations and a community focus on intervention strategies. Figure 2 illustrates the comment distribution within this topic.



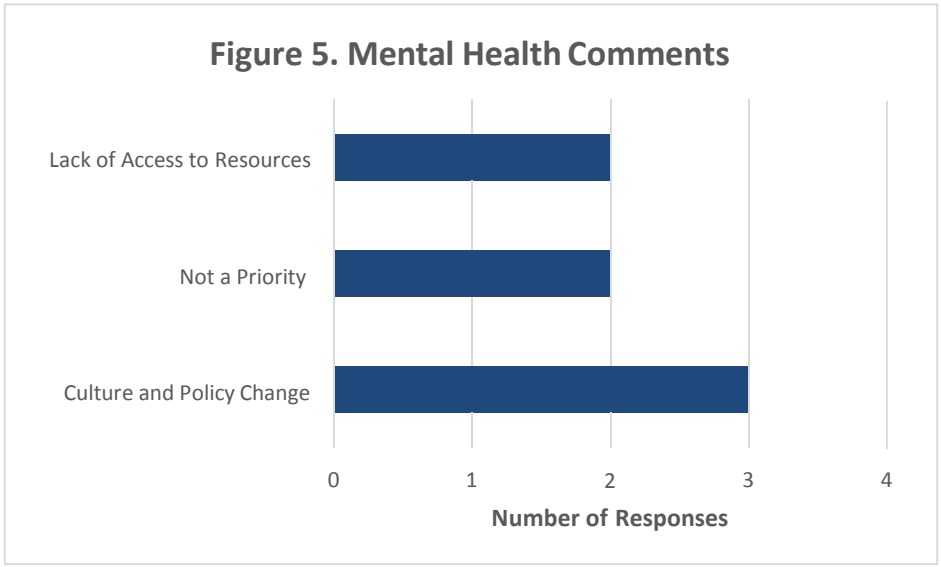
Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: high tobacco incidence, reselling of prescription drugs, overprescribing, treatment options before incarceration and the need for interventions. Figure 3 shows the distribution of comments around these categories.



Nutrition and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for nutrition education (in schools and for families) and increased convenience and availability of exercise opportunities. Sub-categories developed for this summary analysis include exercise opportunities, serving size of food and family education on nutrition. Figure 4 displays comment frequencies for these subgroups.



Mental Health comments were considered separately from substance abuse in order to identify specific mental health needs within the community. The discussion around mental health dealt with lack of access to resources, mental health not being a priority, and culture/policy change. Many felt there was a lack of adolescent mental health care and inpatient facilities. Figure 5 displays comment frequencies for this discussion topic.

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activities
nutrition
advertising
income
environment
Lack
root
together
everyone
seniors
socialization
Public
Lacking
prevent
decrease
problems
Educational
training
working
focus
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screenings
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education
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know
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citizens
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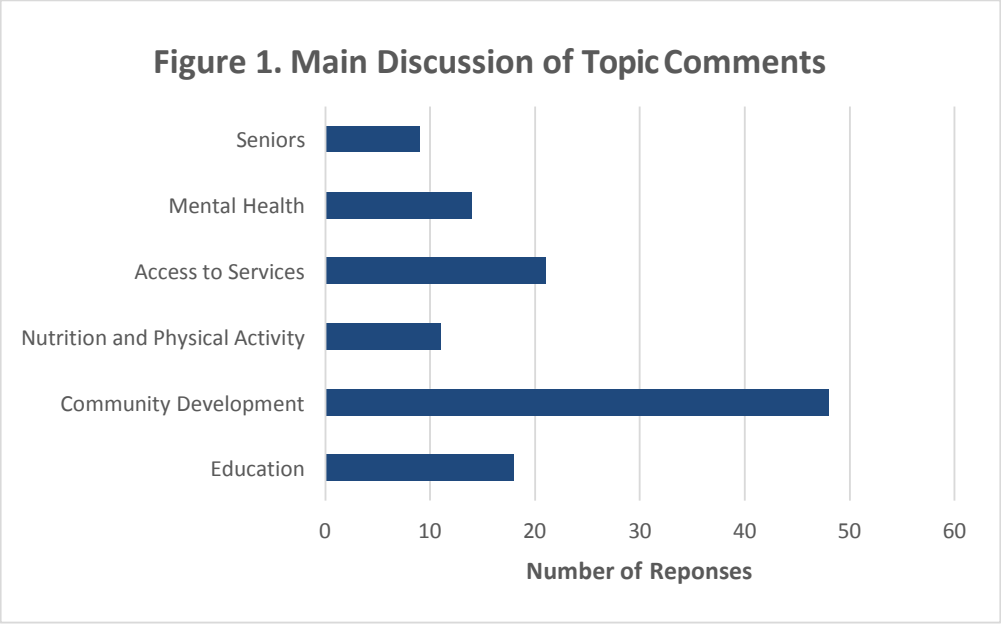
At the Kingsport meeting there were 17 attendees sitting around 4 tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts", to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

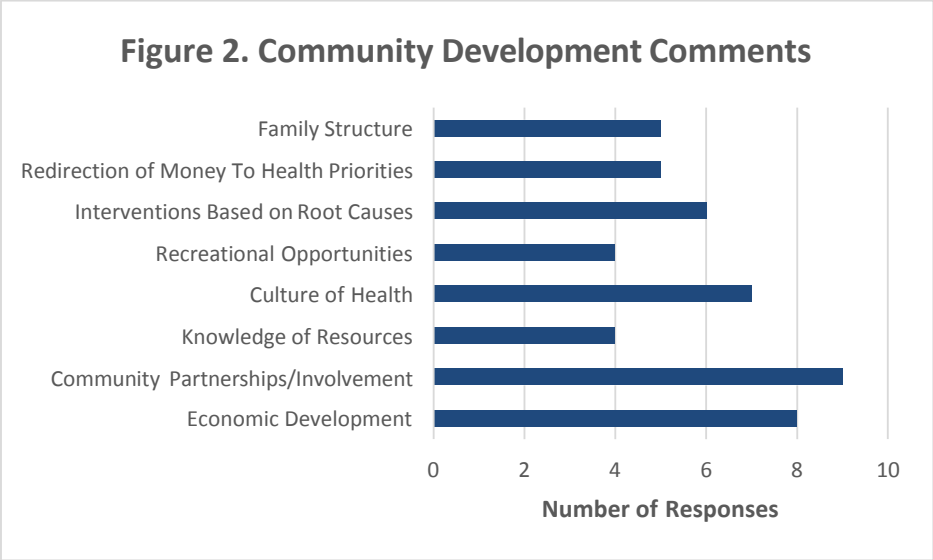
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

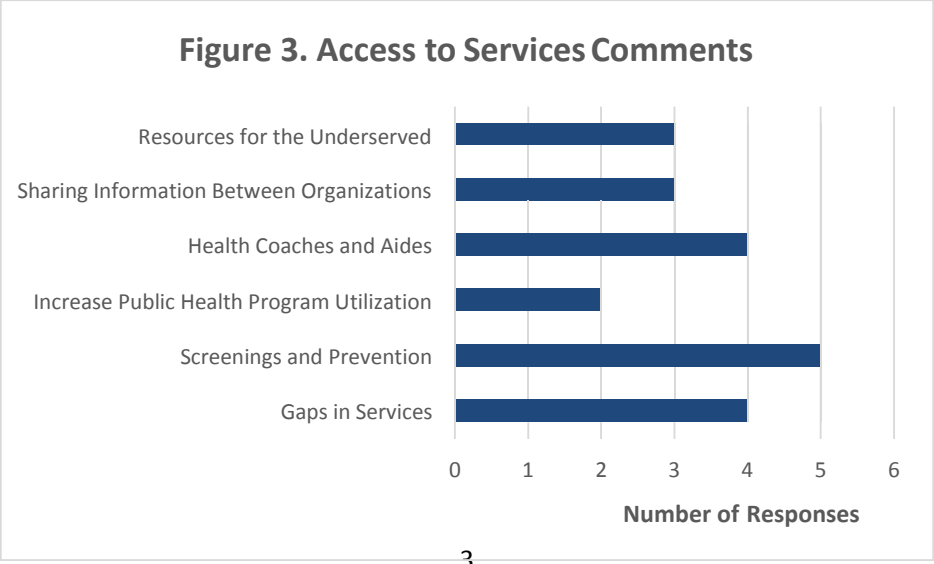
- Education
- Community Development
- Nutrition and Physical Activity
- Access to Services
- Mental Health
- Seniors



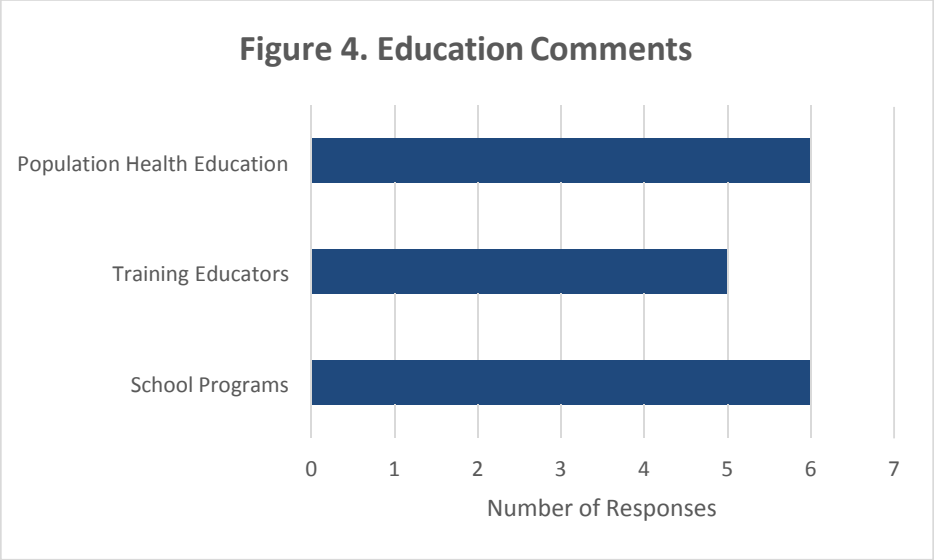
Community Development was characterized by concerns about the family structure, redirection of money to health priorities, interventions based on root causes, increased recreational opportunities, creating a culture of health, knowledge of resources, community partnerships/involvement and economic development. Participant comments included the need for creating jobs, providing opportunities for physical activity and focusing on root based problems. Economic Development was one of the main concerns with decreasing income status, need for reduction of competitive cost and creating a culture where people want to work. Figure 2 displays the rate of comments in each of these categories.



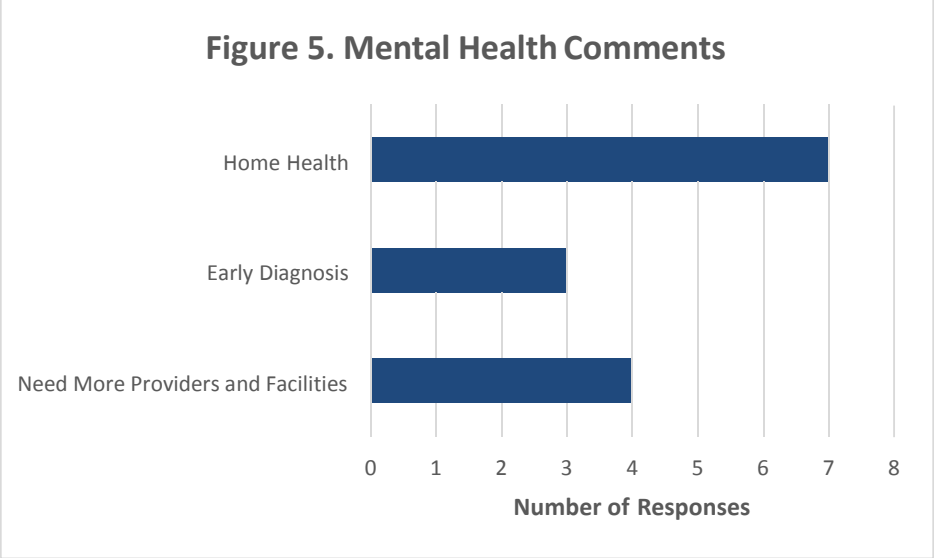
Access to Services was the second largest topic of concern among the attendees. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included resources for the underserved, sharing information between organizations, health coaches and aids, increasing public health program utilization and gaps in services. Programs needed ranged from prevention, educational needs in home health and better sharing of information between organizations. Figure 3 illustrates the comment distribution within this topic.



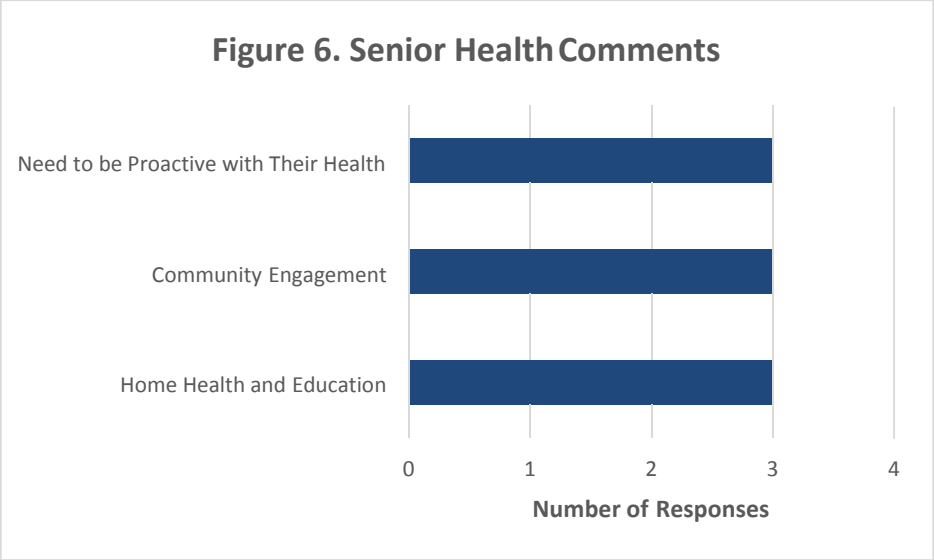
Education is a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were school programs, training educators and population health education. Participants indicated the need for training focus to be based on local issues, literacy and children new healthy habits. Figure 4 displays comment frequencies within the subgroups.



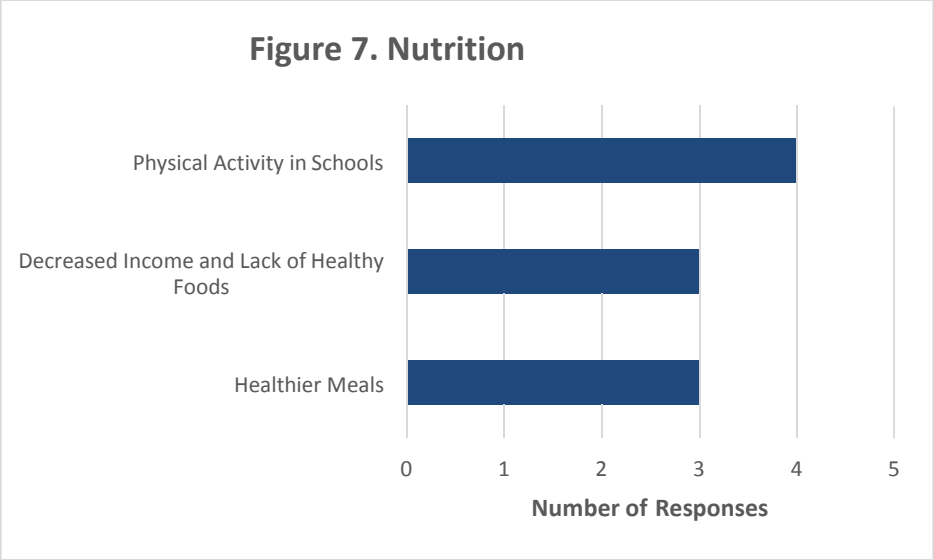
Mental Health comments were focused around needed services. The discussion around mental health dealt with home health services, early diagnosis and the need for more practitioners. Many felt there was a lack of adolescent and pediatric mental health services and mental health treatment facilities. Figure 5 displays comment frequencies for this discussion topic.



Senior Health was concentrated on the need for engagement and access to services. Folks indicated that home health and education, community engagement and the need to be proactive with their health were main concerns. Access to preventive care, need for better way to get services to seniors and education on existing resources were some of the topics mentioned. Figure 8 displays comment frequencies for these subgroups.



Physical Activity and Nutrition was a prominent concern among the meeting participants. Folks indicated that lack of physical activity and the need for more tailoring of dietetic information. Decreasing income and the lack of healthy foods, physical activity in schools and healthier meals were the subcategories expressed in the meeting. Figure 7 displays Comment frequencies for these subgroups.



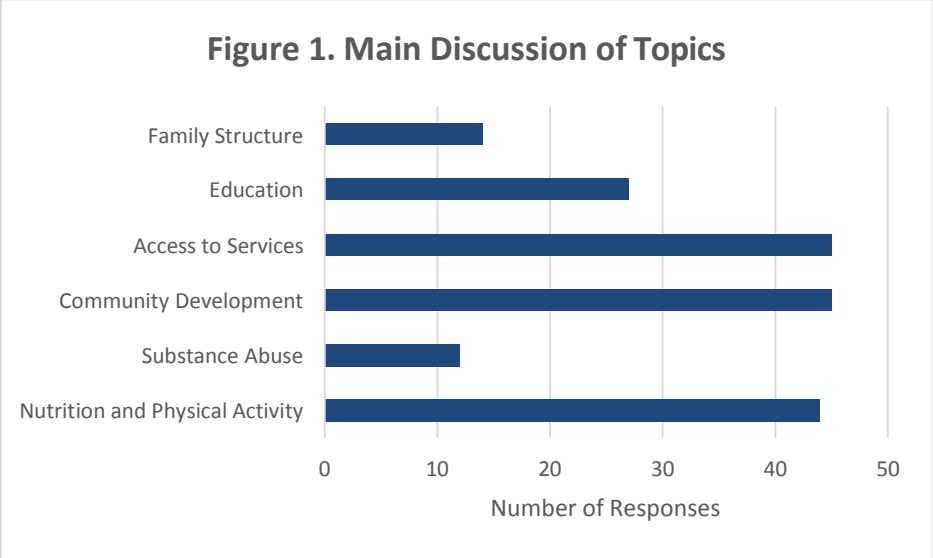
Qualitative Data Summary
Lebanon Community Health Roundtable meeting
September 29, 2015

At the Lebanon meeting there were 36 attendees sitting around six tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

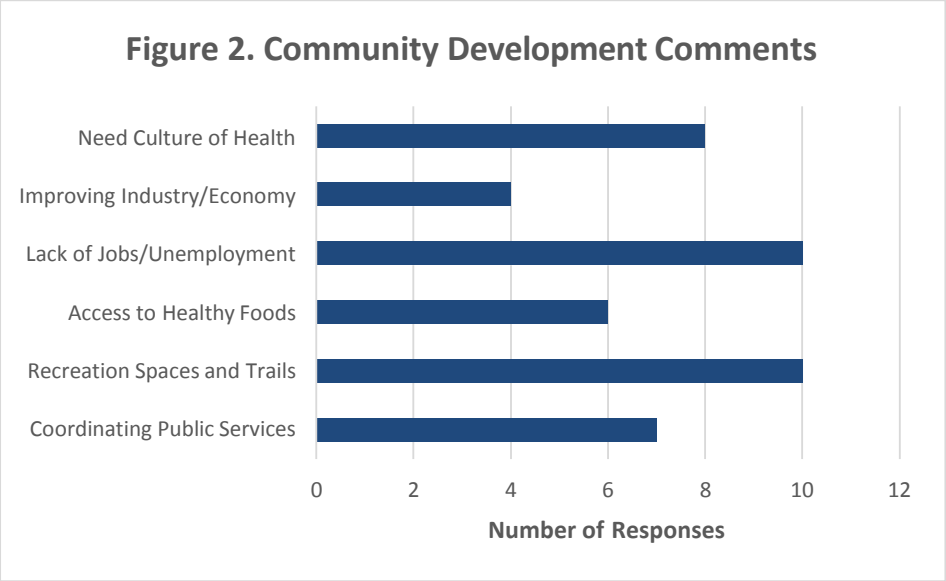
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

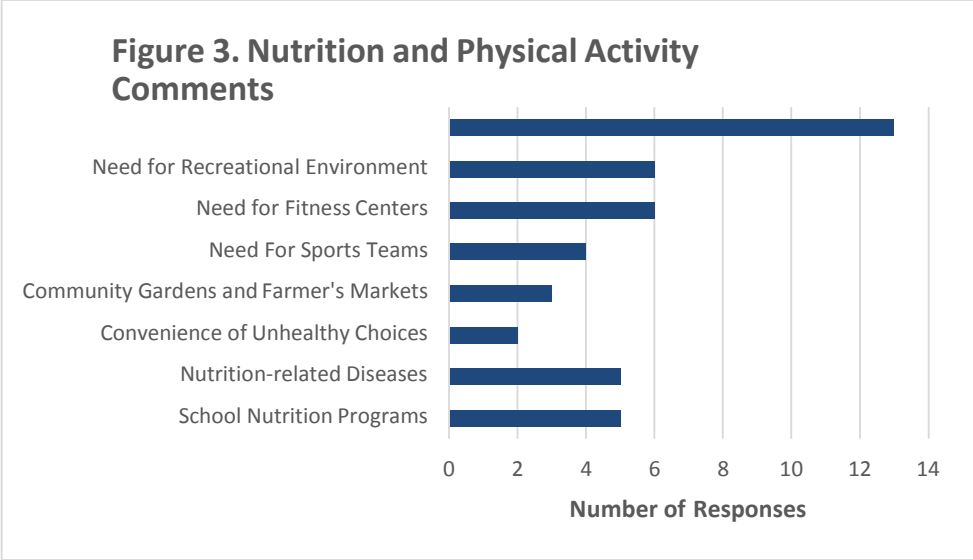
- Nutrition and Physical Activity
- Substance Abuse
- Community Development
- Access to Services
- Education
- Family Structure



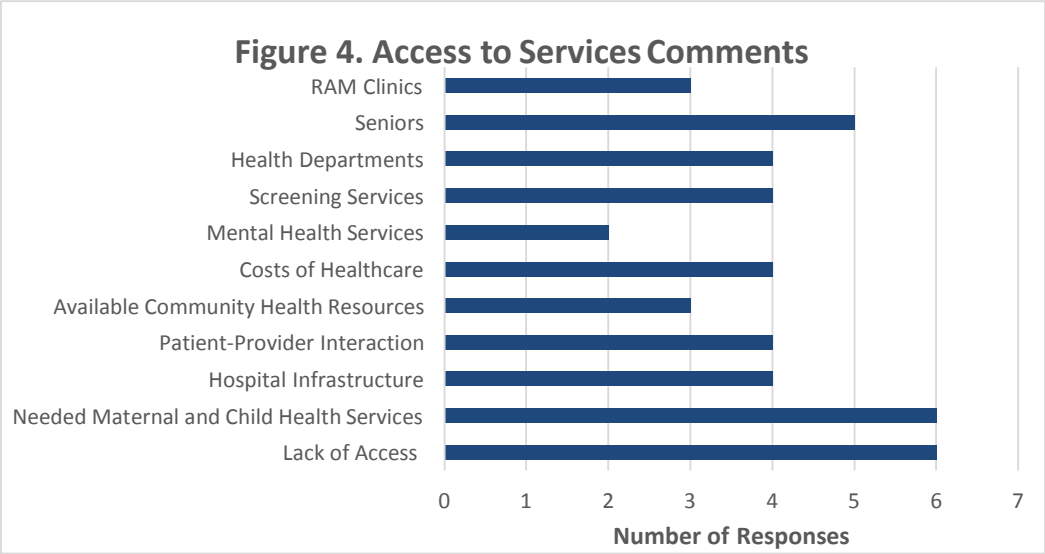
Community Development was characterized by concerns about establishing a culture of health, improving industry and the economy, lack of jobs/unemployment, access to healthy foods, recreation spaces and trails and coordination of public services. Figure 2 displays the rate of comments in each of these categories.



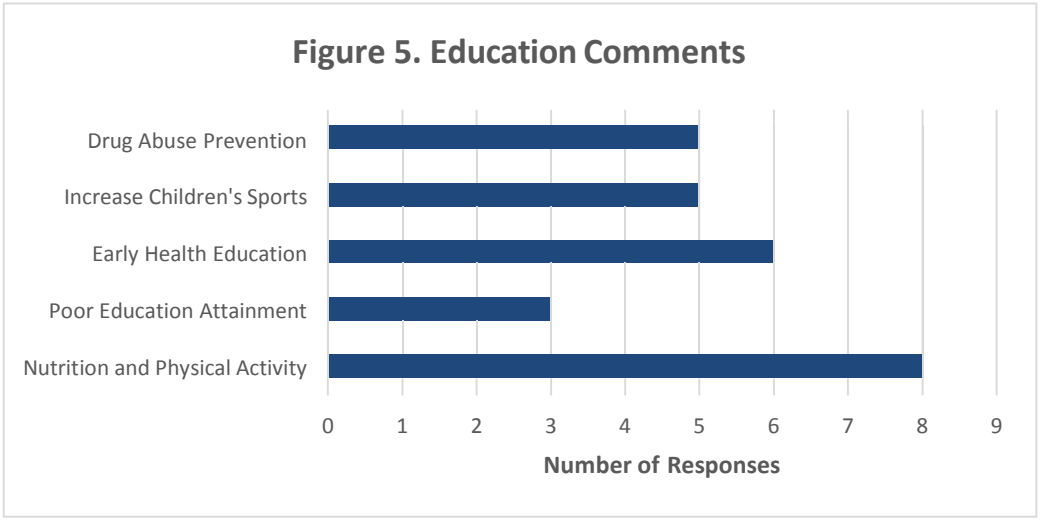
Nutrition and Physical Activity was a prominent concern among the meeting participants. People attending indicated a need for a recreational environment, need for more fitness centers and sports teams, community gardens and farmer's markets, the convenience of unhealthy choices, nutrition-related diseases, school nutrition programs and education. Folks mentioned specific needs for exercise trails, children's sports teams and fitness centers in the community. Figure 3 displays comment frequencies for these subgroups.



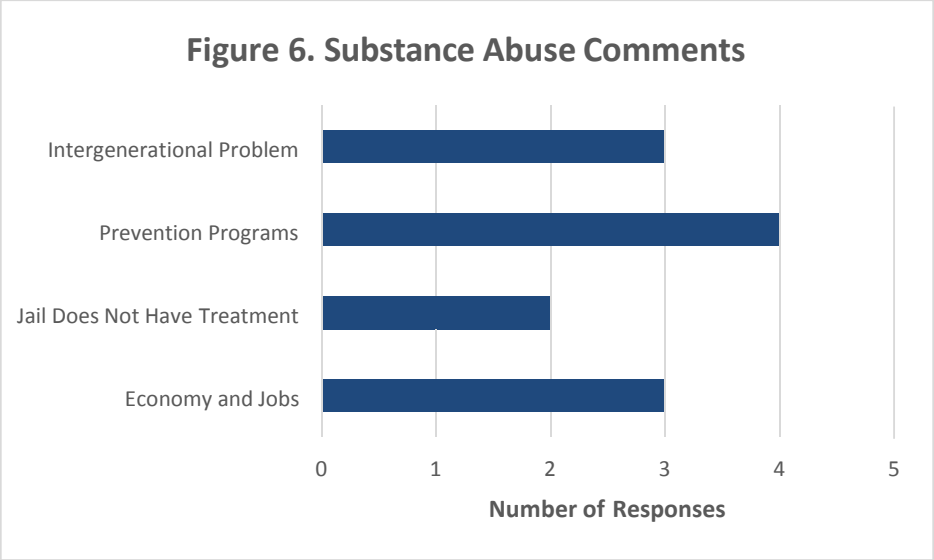
Access to Services was a major topic of concern among the attendees. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included lack of access to services, maternal and child health services, hospital infrastructure, patient-provider Interaction, available community health resources, cost of health care, and the need for mental health services, screening services, health departments, seniors and RAM clinics. Programs needed ranged from pediatricians, transportation, senior exercise classes and reduction of health care costs. Figure 4 illustrates the comment distribution within this topic.



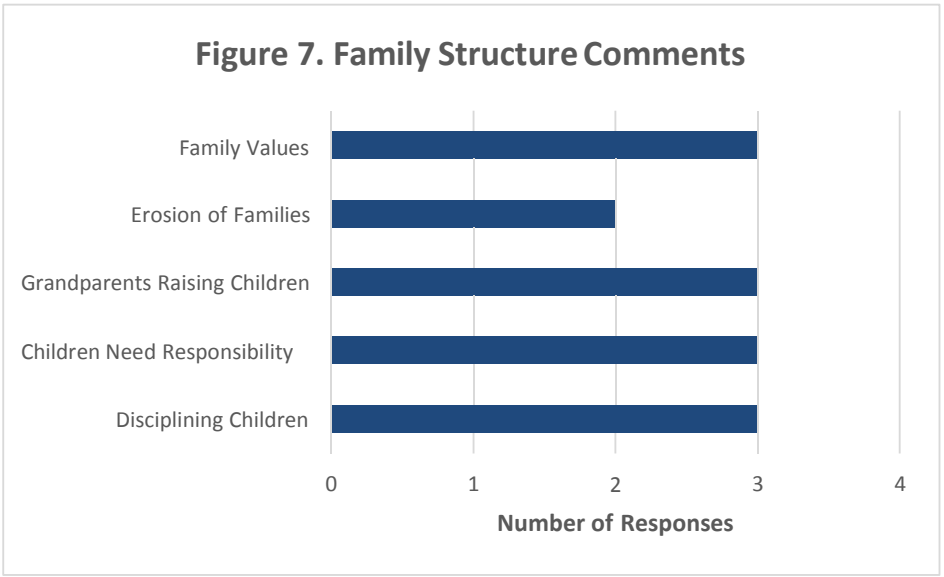
Education is a broad topic that was prevalent within the majority of discussion topics. Participants indicated the need for drug abuse prevention, increasing children's sports, early health education, nutritional and physical activity as well as the problem of poor educational attainment. Ideas specific to the types of education, the targeted age group, as well as setting were included in this major topic. Subgroups within the topic were early education for children, self-esteem and more physical activity in schools. Figure 5 illustrates the comment distribution within this topic.



Substance Abuse was another concern among the attendees. Focus areas within this topic included: jails lacking treatment for addicts, economy and jobs, the need for prevention programs and drug abuse as an intergenerational problem. There were not any specific substances identified from the notes. Figure 6 shows the distribution of comments around these categories.



Family Structure comments were considered separately from Community Development in order to identify specific culture and family structural concerns within the community. Focus areas within this topic included: family values, erosion of family structure, grandparents raising children, children needing responsibility and the need to discipline children. Figure 7 shows the distribution of comments around these categories.



Qualitative Data Summary
Elizabethton Community Health Roundtable meeting
August 13, 2015

Qualitative Data Summary
Elizabethton Community Health Roundtable meeting
August 13, 2015

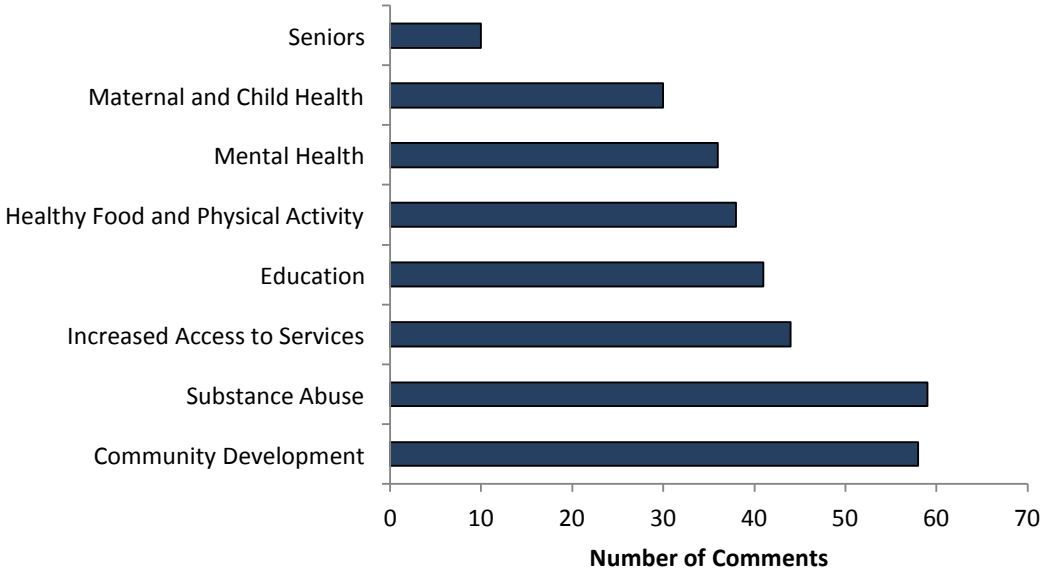
At the Elizabethton meeting there were 48 attendees sitting around eight tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

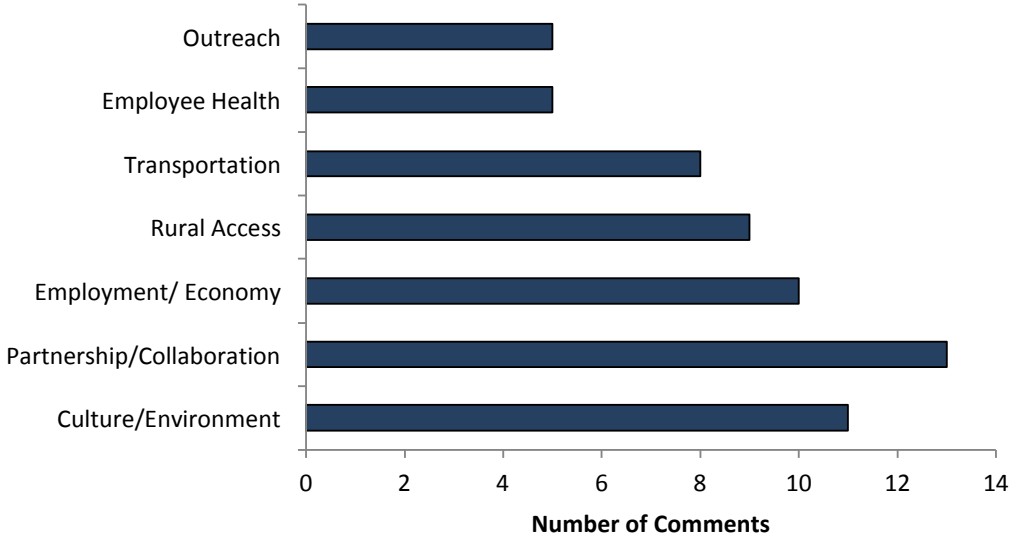
- Community Development
- Substance Abuse
- Increased Access to Services
- Education
- Healthy Food and Physical Activity
- Mental Health
- Maternal and Child Health
- Seniors

Figure 1. Main Discussion Topic Comments



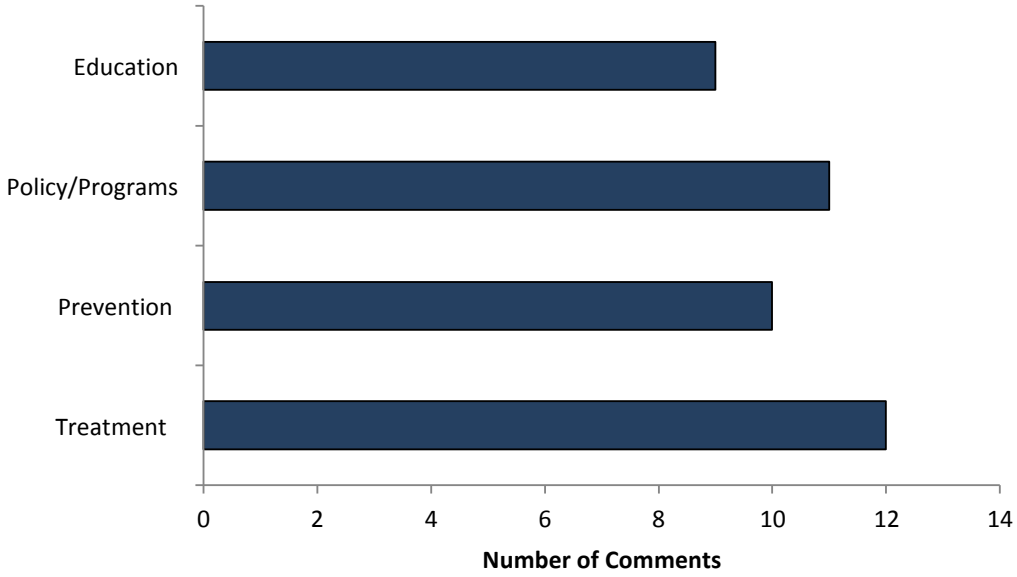
Community Development was characterized by concerns about the local environment, employment, collaborative infrastructure (government and private sector partnerships), rural access to services, transportation, employee health and outreach. Figure 2 displays the rate of comments in each of these categories.

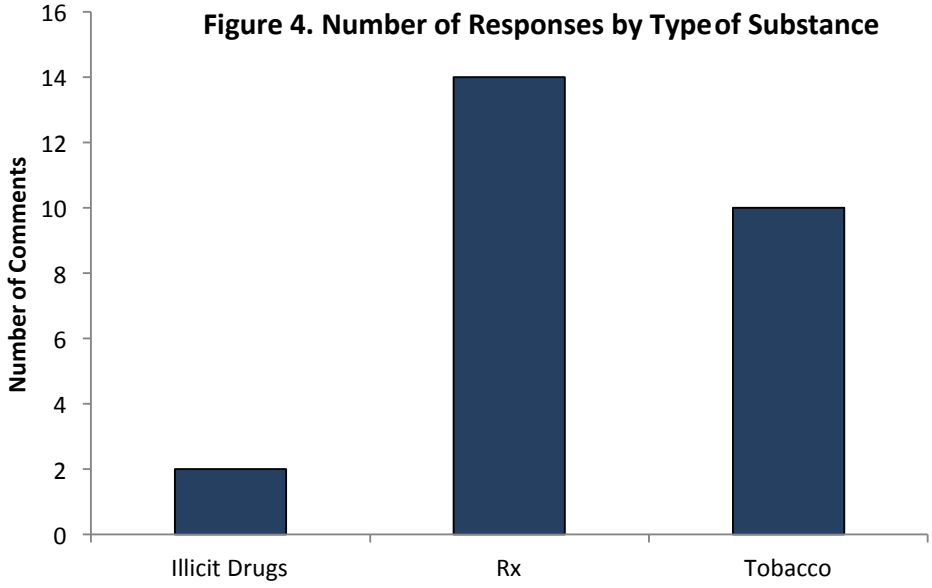
Figure 2. Community Development Comments



Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: treatment services access and development, prevention services, policy and programs and education. There were three categories of substances identified from the notes (illicit drugs, prescription drugs and tobacco) Figure 3 shows the distribution of comments around these categories. Figure 4 displays the frequency of comments for each of the three identified substances (illicit drugs, prescription drugs and tobacco).

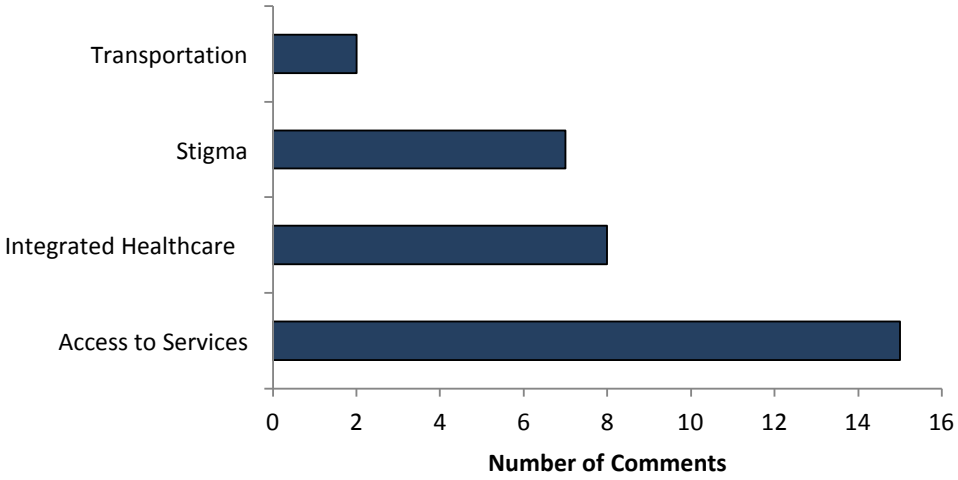
Figure 3 Substance Abuse Comments





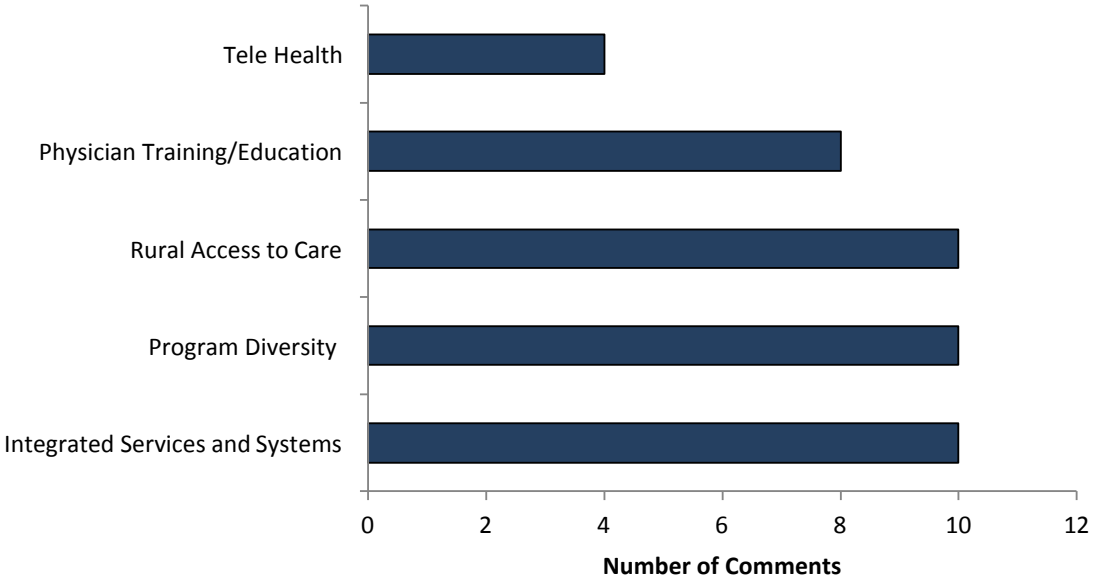
Mental Health comments were considered separately from substance abuse in order to identify specific mental health needs within the community. The discussion around mental health dealt with access to services, integrated health care, stigma and transportation concerns. Many felt there was a lack of inpatient and outpatient services in the region and that stigma was a substantial barrier to treatment. Figure 5 displays comment frequencies for this discussion topic.

Figure 5. Mental Health Comments



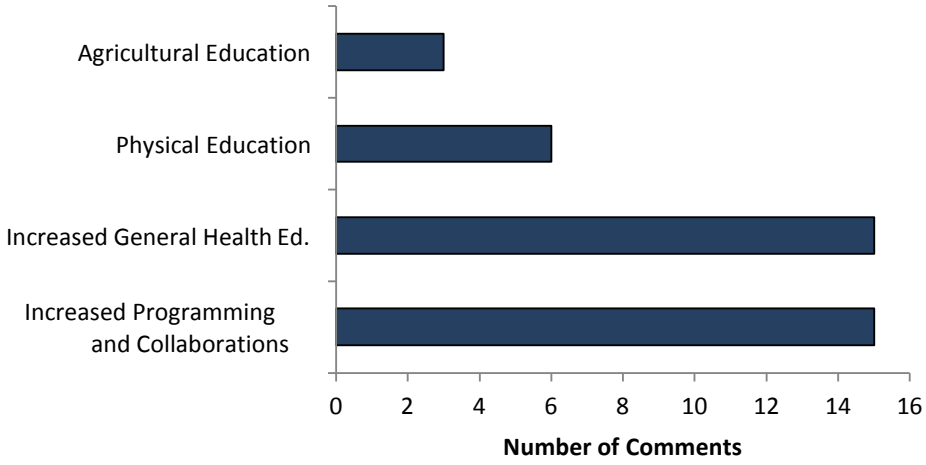
Increased Access to Services was a concern across all the main topics of discussion. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included integrated services and systems, program diversity, rural access to care, physician training/education and telemedicine. Integrated services and systems comments dealt with the need for collaborations between physicians, insurance companies and the community as well as a strong need for integrated data solutions. Program diversity included comments around the need for oral care and behavioral health in the primary care setting. Figure 6 illustrates the comment distribution within this topic.

Figure 6. Increased Access to Services Reponses



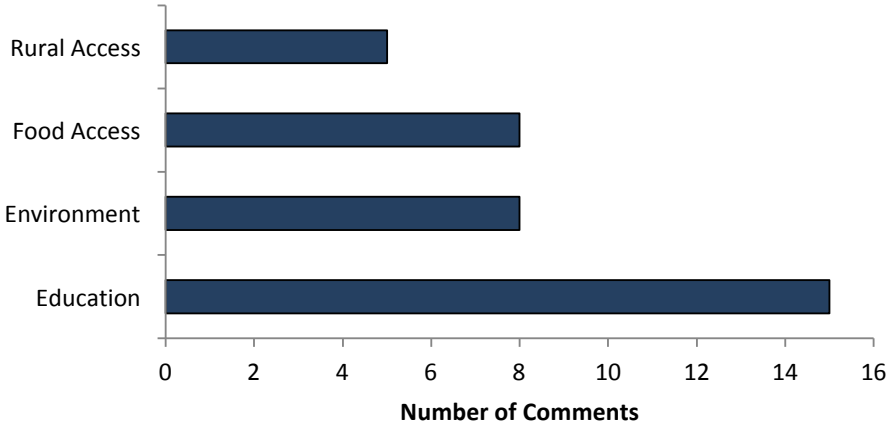
Education is a broad topic that was prevalent within every major discussion topic. Ideas specific to the types of education, the targeted age group and setting were included in this major topic. Subgroups within the topic were increased programming and collaborations, increased general health education, physical education and agricultural education. Participants indicated the need for increased resources, education outside of the schools and collaborative school system infrastructures. The agricultural education component dealt with the development of community and school gardens, a concept seen across the discussion topics. Figure 7 displays comment frequencies within the subgroups.

Figure 7. Education Comments



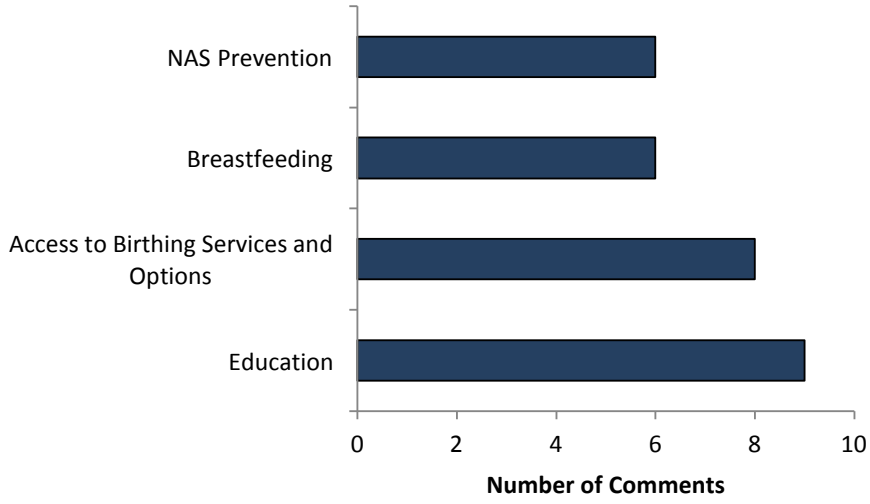
Healthy Food and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for nutrition education and physical activity in schools, as well as the need for environmental changes and improvements to increase physical activity. Access to fresh food and the concept of food deserts was a concern expressed in the meeting. Sub-categories developed for this summary analysis include education, environment, food access and rural access. Figure 8 displays comment frequencies for these subgroups.

Figure 8. Healthy Food and Physical Activity Comments



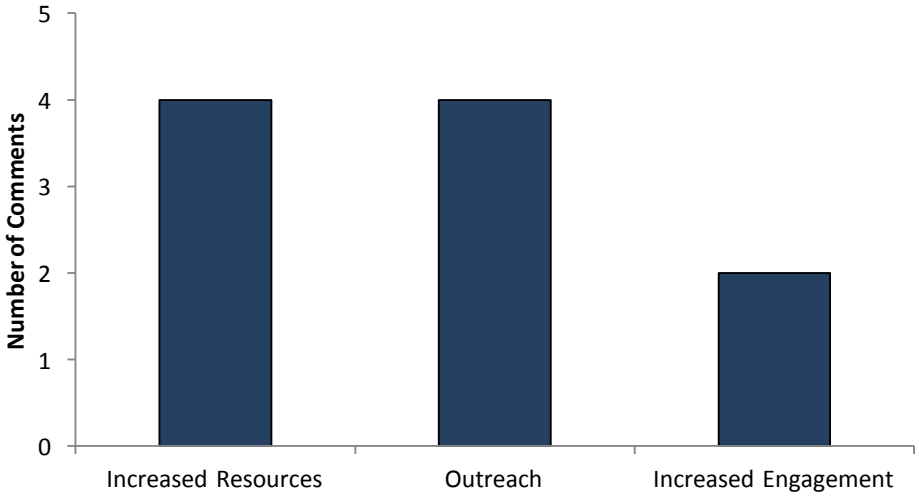
Maternal and Child Health discussions were centered in large part around educating the community about risky behaviors and pregnancy. A large percentage of the comments on this topic also dealt with increasing access to birthing services and options such as midwives and mother-friendly childbirth. Participants also indicated a need to encourage breastfeeding within the community and a non-specific set of comments called for the prevention of neonatal abstinence syndrome (NAS). Figure 9 displays comment frequencies for this discussion topic.

Figure 9. Maternal and Child Health Comments



Senior health was the discussion topic with the least comments of all the categories. Participants citing this population as one in need of attention discussed the potential benefits of increased resources (family, housing, etc.), outreach efforts such as educating the public and increased engagement with the senior community through activities and collaborative centers. Figure 10 displays the comment frequencies within this discussion topic.

Figure 10. Senior Comments




education
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substance
nutrition
Obesity
school
Lack
Nutrition
Change
intensive
drug
Policy
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skills
Need
access
hospitals
behavior
build
health
communities
community
schools
trails
Increase
classes
moving
Walking
beyond
prevention
services
Transportation
football
environment
Public
transportation
people
overall
problem
soda
resources
lifestyle
abuse
lack
families
start
barriers
issues
line
state
hospital
youth
treatment
meals
develop
home
opportunities
smoking
poverty
healthy
make
medical
violence
back
cessation
Poor
attractive
money
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look
across
role
Personal
responsibility
area
based
continuous
changing
improve
involvement
mindsets
increasing
working
Money
something
Hopelessness
educate
Social
industry
Anti-smoking
college
create
Remove
ideas
year
one
reduce
starting
summer
career
bring
issue
Children
w/o
cooperative
sports
step
Concussion
Early
looking
relationships
backpack
just
kids
machines
rural
impact
stabilization
practice
stores
state/county
happen
population
valuing
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grocery
family
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cycle
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economy
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rate
Abuse
policy
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use
taxi
lower
soft
license
focus
Symposium
working
giving

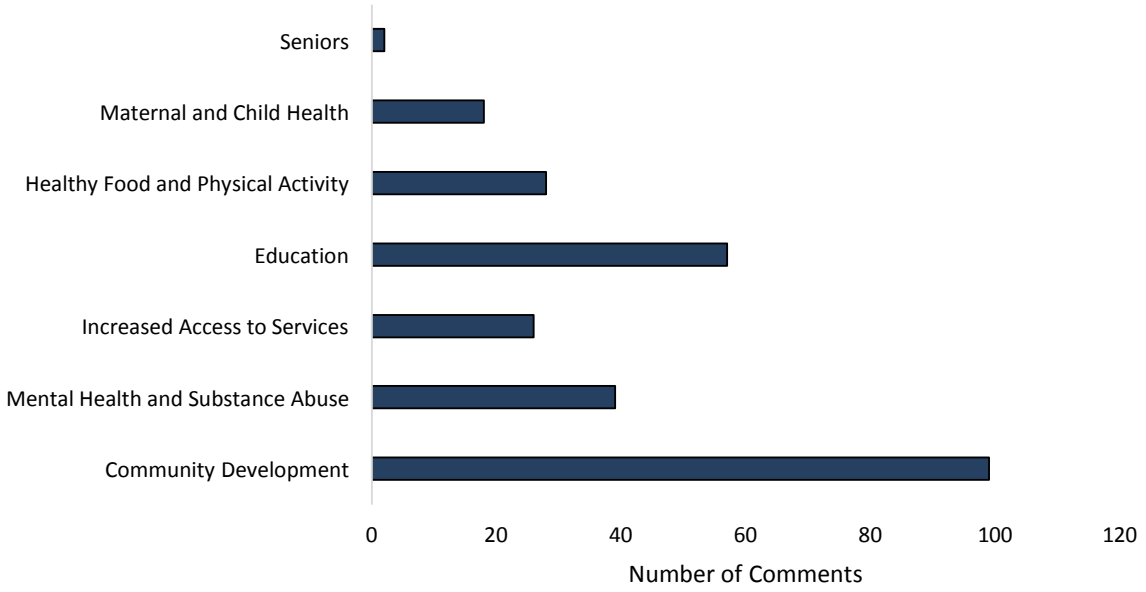
At the Abingdon meeting there were 40 attendees sitting around eight tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable Meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

Main Topics of Discussion

Below are the major categories of discussion among the participants, within which several sub-categories have been identified.

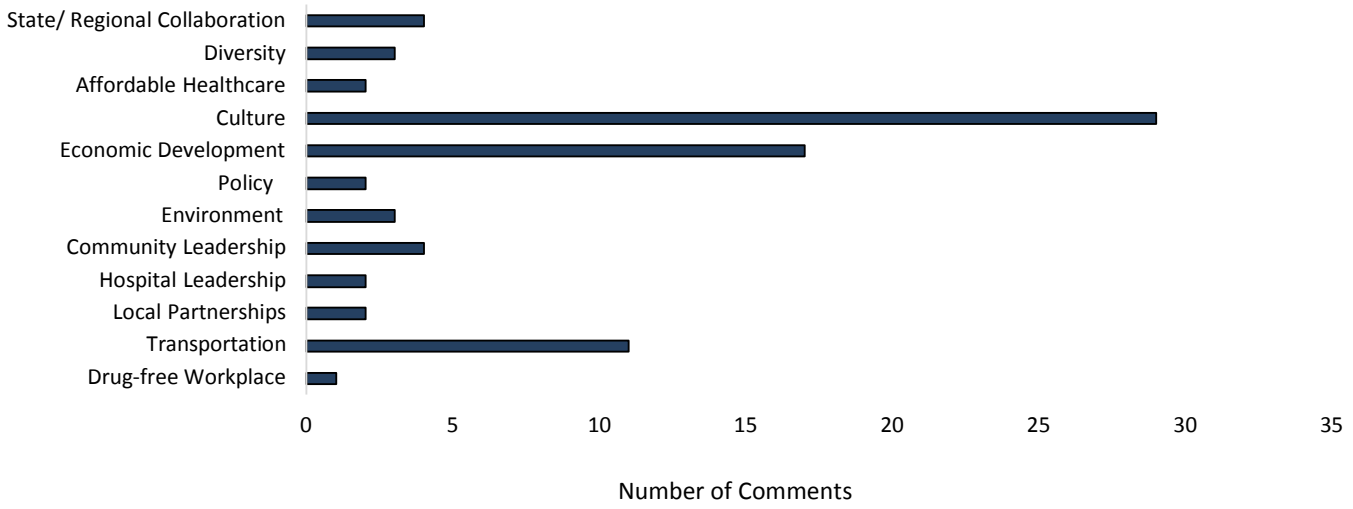
- Community Development
- Mental Health Substance Abuse
- Increased Access to Health Services
- Education
- Healthy Food and Physical Activity
- Maternal and Child Health
- Seniors

Figure 1. Community Comment by Discussion Topic Area



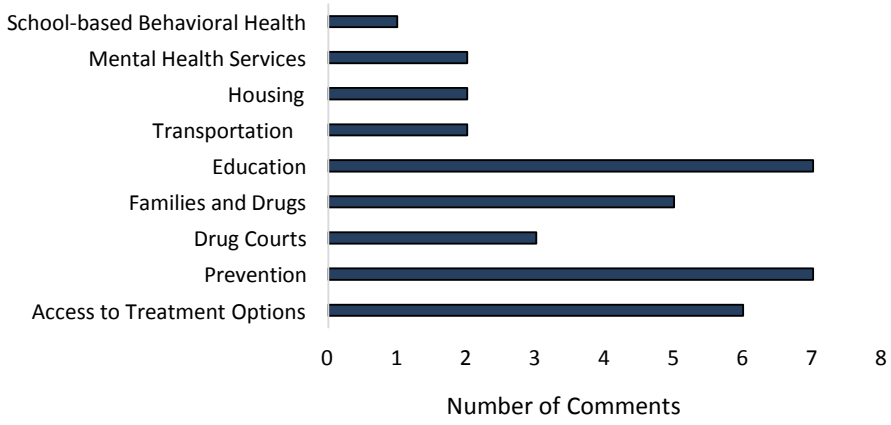
Community Development was a topic of discussion that dealt with the need for increased support and cohesion across the region to ensure a healthier community. Concerns within this topic included the local environment, economic development, the need for partnerships to increase resources for health care, transportation, employee health and outreach. Figure 2 displays the rate of comments in each of these categories.

Figure 2. Community Comments on Improving Health through Community Development



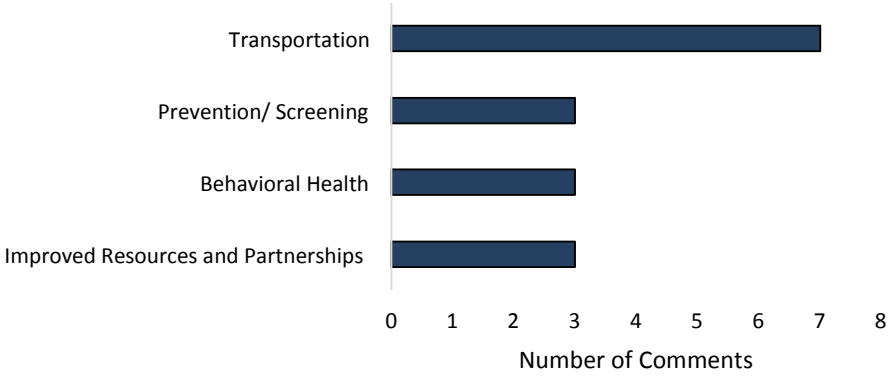
Mental Health and Substance Abuse was the third largest topic of concern among the attendees. Focus areas within this topic included: treatment services access and development, prevention services, policy and programs, family support and school-based programming.

Figure 3. Community Comments on Mental Health and Substance Abuse



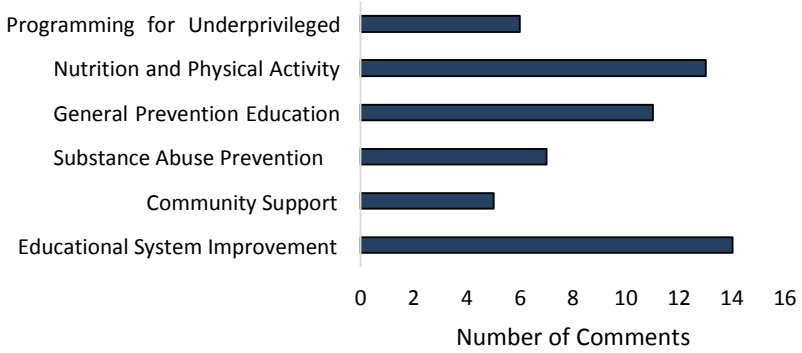
Increased Access to Services was a concern across all of the main topics of discussion. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included transportation, prevention/ screening, behavioral health and improved collaboration to better leverage resources. The comments in the last category, improved resources and partnerships, dealt with the need for collaborations between physicians, insurance companies and the community as well as a strong need for integrated data solutions.

Figure 4. Community Comments on Ensuring Access to Health Care

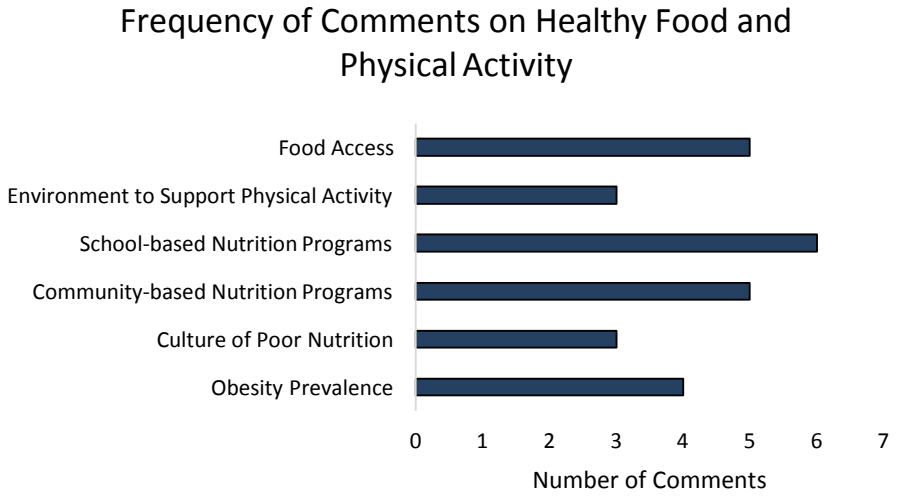


Education was the second most identified category of problem and potential solutions. Comments around this topic focused on the need to improve the current education system through community support and programs for underprivileged families. Attendees also cited a need for substance abuse education to reduce stigma and decrease rates of substance abuse in children and families. An increase in prevention education including nutrition education was also noted by the group.

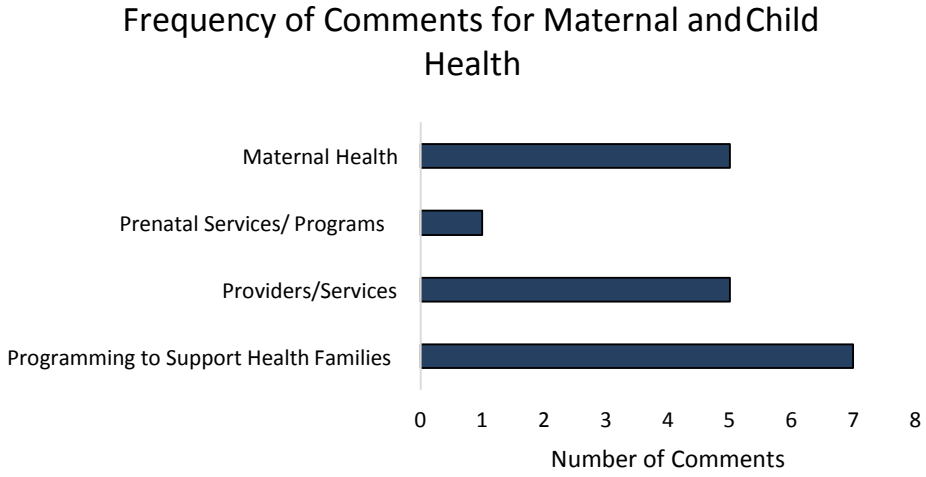
Community Comments on Education



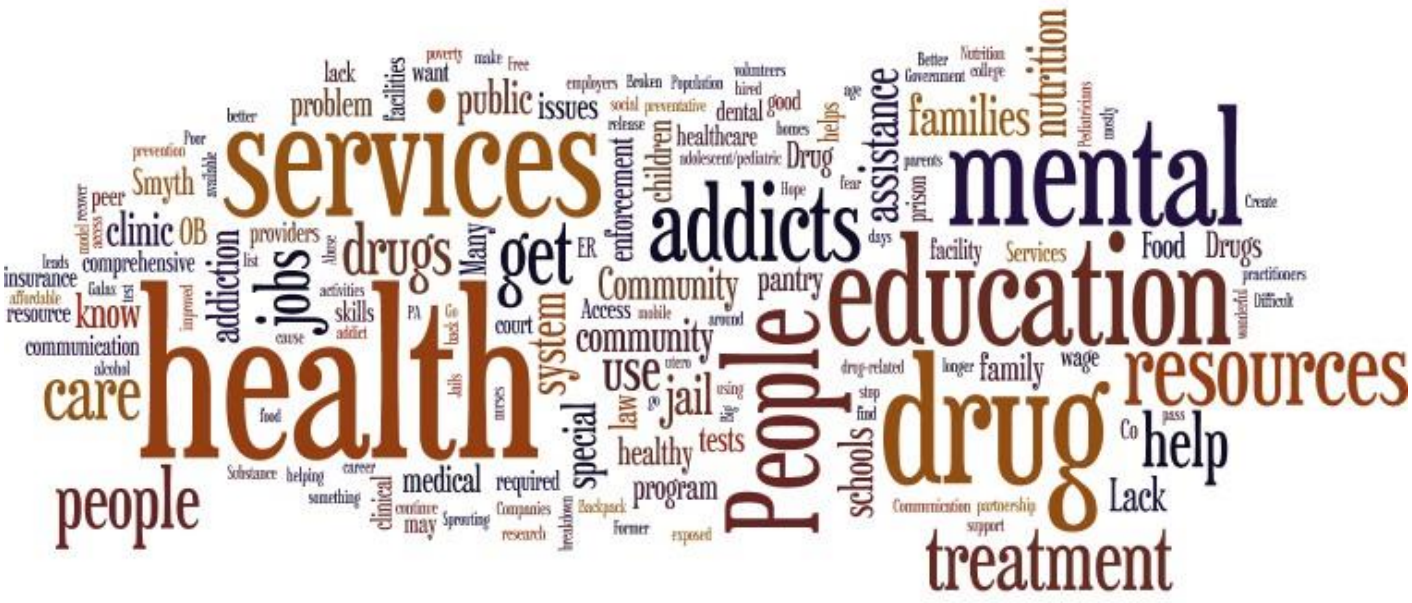
Healthy Food and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for nutrition education and physical activity in schools, as well as the need for environmental changes and improvements to increase physical activity. Comment frequencies for these subgroups.



Maternal and Child Health discussions were centered around educating the community about risky behaviors and pregnancy. A large percentage of the comments on this topic also dealt with increasing access to services, maternal education regarding health and programming to support the family before and after birth.



Senior health was the discussion topic with the least comments of all the categories. Participants concerned about the senior population called for more overall engagement by the community and increased resources to keep this population supported and healthy.


health
services
People
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jobs
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addiction
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communication
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insurance
comprehensive
Smyth
peer
OB
providers
Many
ER
enforcement
children
assistance
families
nutrition
Drug
healthcare
public
problem
facilities
lack
want
issues
Community
pantry
Access
community
use
jail
court
system
special
law
healthy
tests
program
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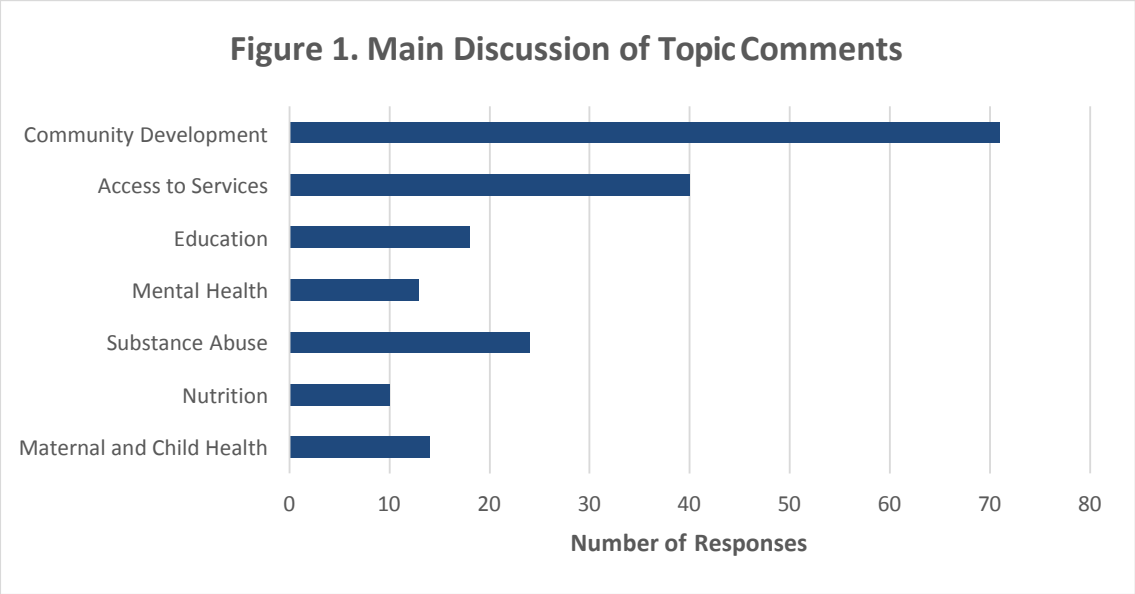
breakdown
Sprouting
continue

At the Marion meeting there were 25 attendees sitting around five tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

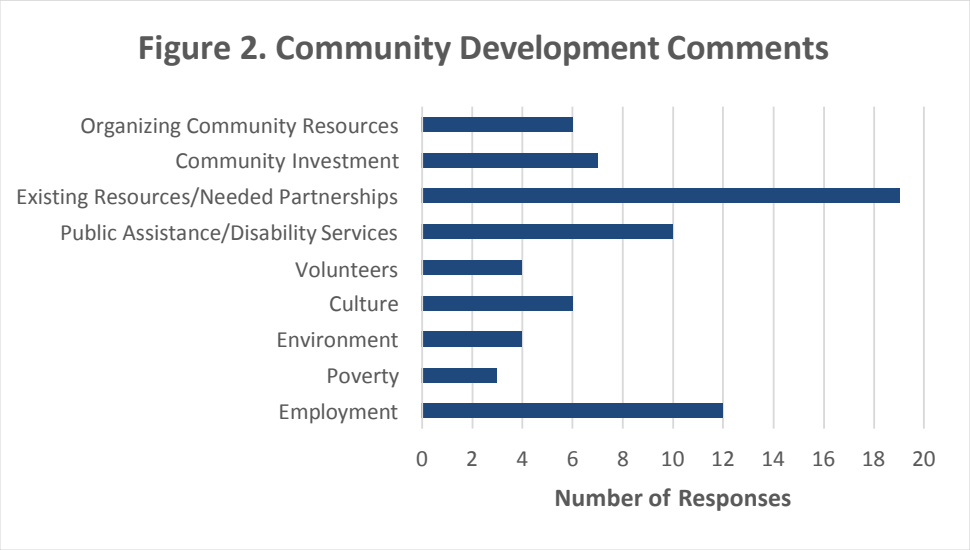
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

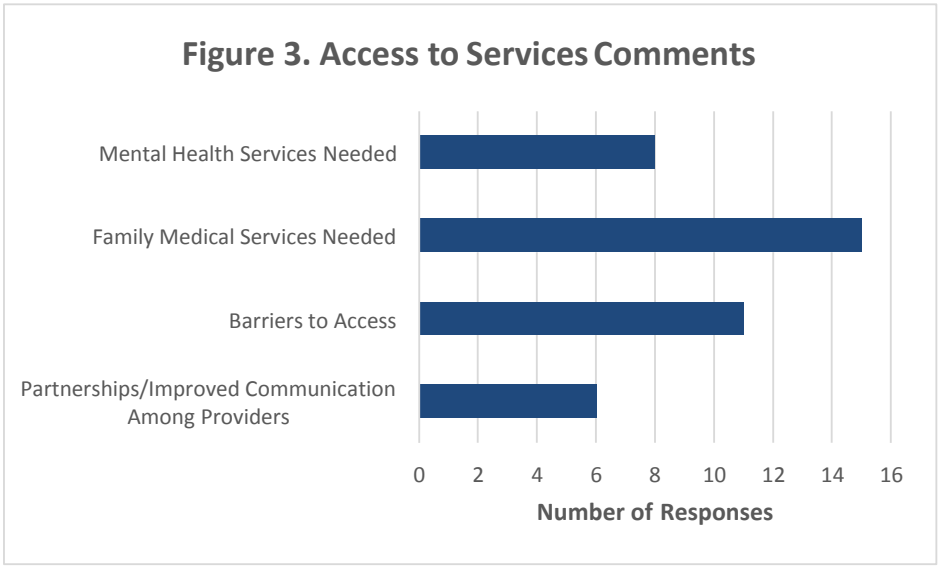
- Community Development
- Substance Abuse
- Access to Services
- Education
- Nutrition
- Mental Health
- Maternal and Child Health



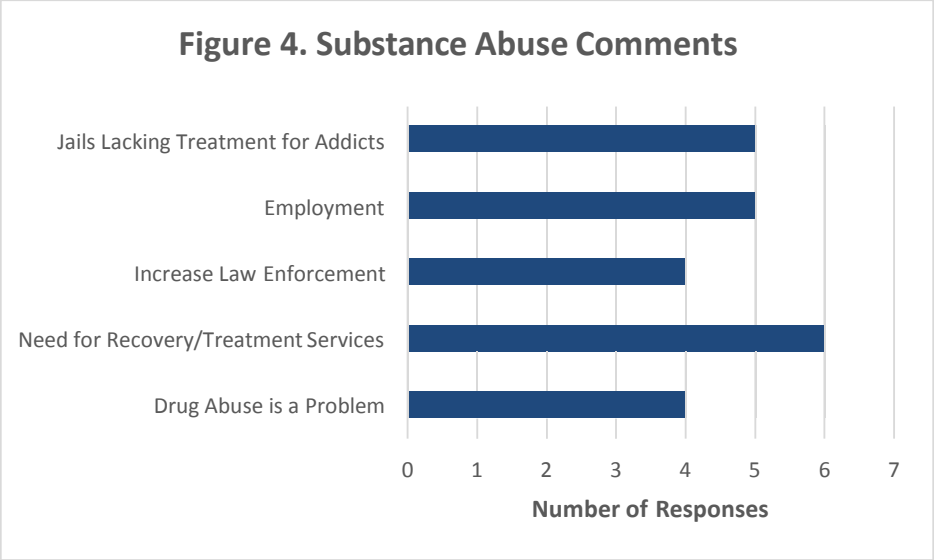
Community Development was characterized by concerns about the existing resources/needed partnerships, organizing community resources, community investment, employment, public assistance/disability services, culture, local environment, volunteer opportunities and poverty. Participants included the need for a mailing of services and locations, increasing the number of job fairs and jobs, and the idea that public assistance should not be generational. Employment was one of the main concerns with career training needs, increasing minimum wage and recruiting professionals to the area. Figure 2 displays the rate of comments in each of these categories.



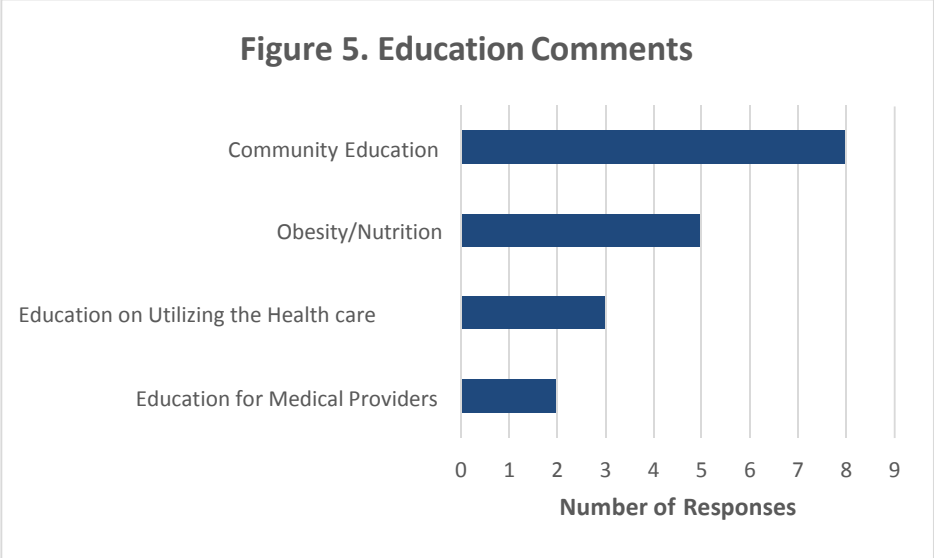
Access to Services was the second largest topic of concern among the attendees. In order to identify specific categories within the discussion around access, comments were broken out and considered individually. Topics under access to services included barriers to access, mental health and family medical services needed and partnerships/improved communication among providers. Programs needed ranged from dental care services, preventive care to adolescent mental health services and OB/GYN. Figure 3 illustrates the comment distribution within this topic.



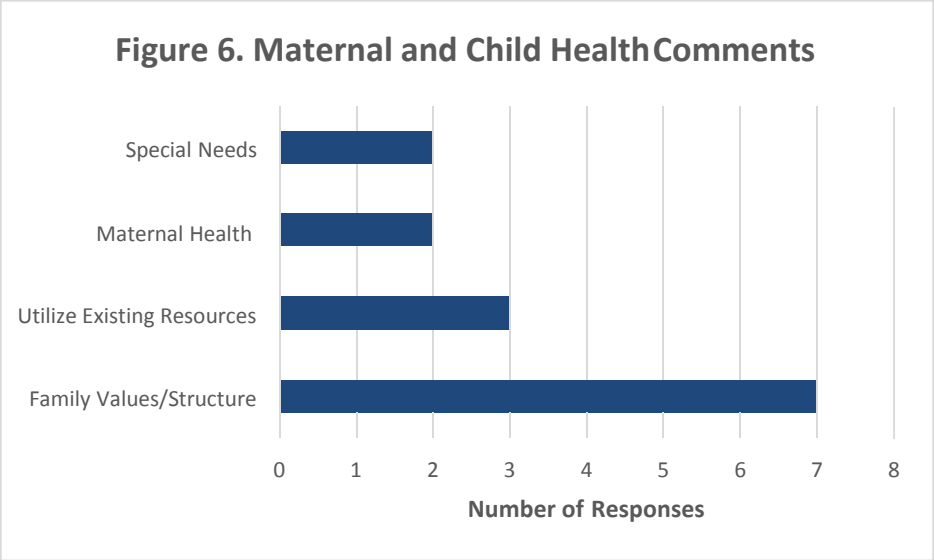
Substance Abuse was the third largest topic of concern among the attendees. Focus areas within this topic included: jails lacking treatment for addicts, employment, increasing law enforcement, need for recovery/treatment services and overall agreement that drug abuse is a problem. There were not any specific substances identified from the notes. Figure 4 shows the distribution of comments around these categories.



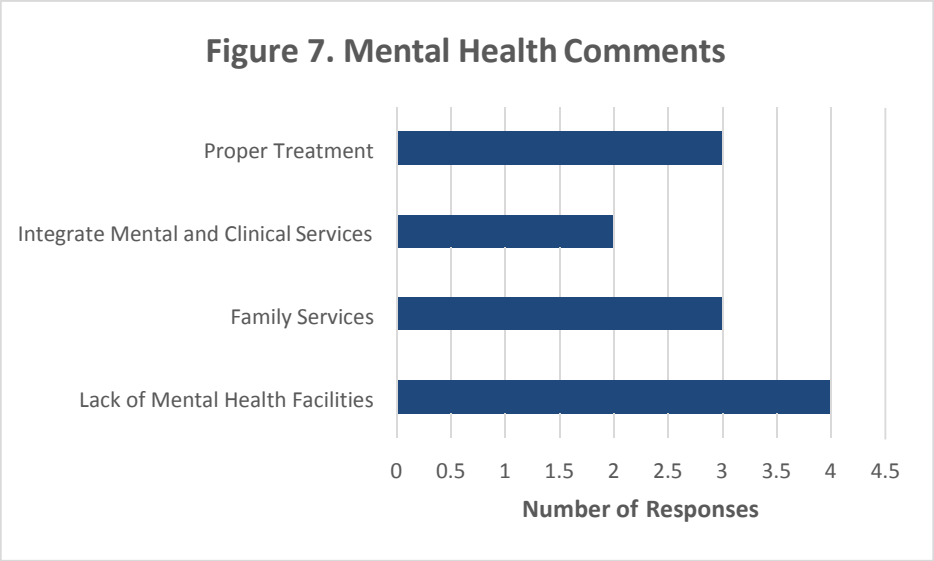
Education is a broad topic that was prevalent within every major discussion topic. Ideas specific to the types of education, the targeted age group and setting were included in this major topic. Subgroups within the topic were community health, obesity/nutrition and education for medical providers and accessing/using the health care system. Participants indicated the need for medical education and education on navigating the health care system and where to go. Figure 5 displays comment frequencies within the subgroups.



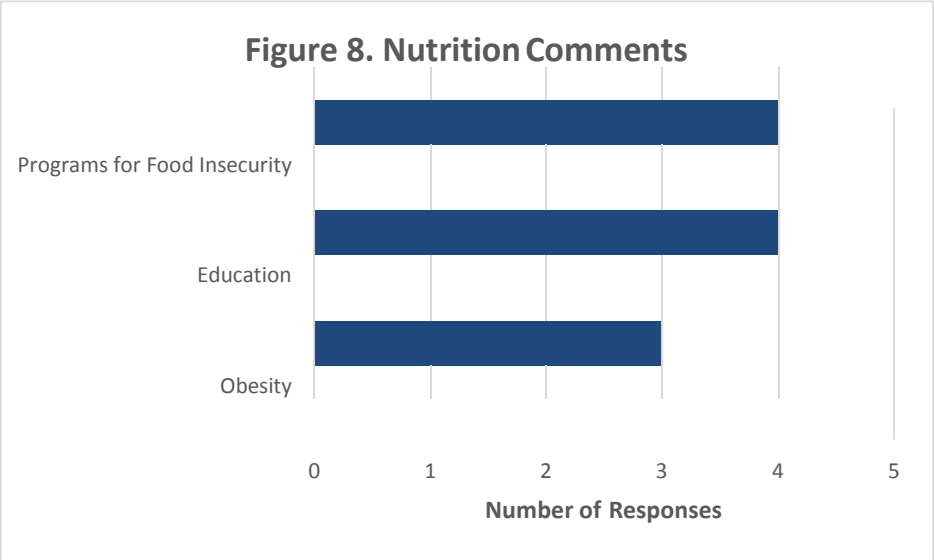
Maternal and Child Health discussions were centered in large part family values and family structure. A large percentage of the comments on this topic also dealt with grandparents raising grandchildren, the need for OB services and care for special needs. Participants also mentioned existing resources and the increase of single parents. Figure 6 displays comment frequencies for this discussion topic.



Mental Health comments were considered separately from substance abuse in order to identify specific mental health needs within the community. The discussion around mental health dealt with integrated mental and clinical services, family services and lack of mental health facilities and proper treatment. Many felt there was a lack of adolescent and pediatric mental health services and mental health treatment facilities. Figure 7 displays comment frequencies for this discussion topic.



Nutrition was a prominent concern among the meeting participants. Participants indicated that obesity is a problem in the community and nutrition education is needed in the schools. Access to food pantries and community gardens were listed as some of the ideas expressed in the meeting. Sub-categories developed for this summary analysis include education, obesity and programs for food insecurity. Figure 8 displays comment frequencies for these subgroups.



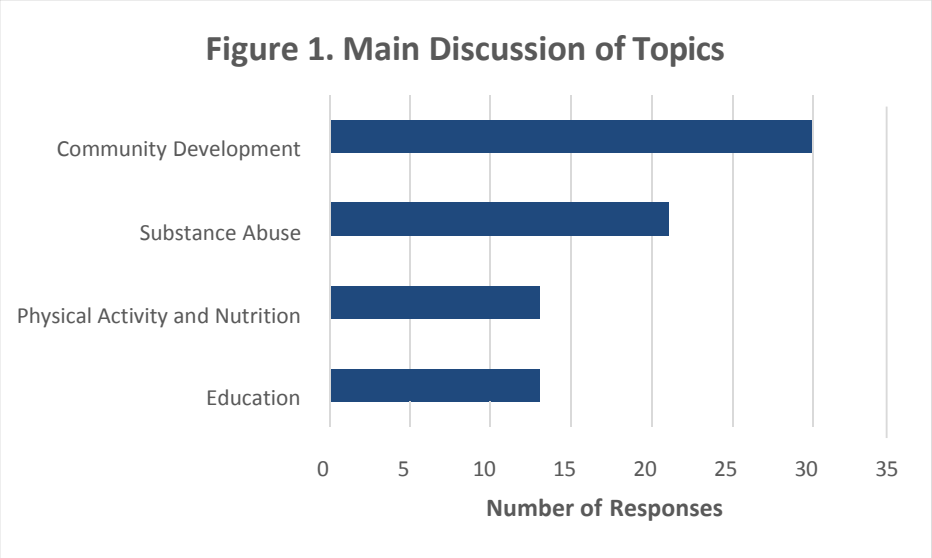
Qualitative Data Summary
Erwin Community Health Roundtable meeting
September 24, 2015

At the Erwin meeting there were 11 attendees sitting around three tables. Data were captured using the World Café approach to large group discussion, which yields a set of notes taken by table moderators during small group discussions taking place over multiple rounds. For the purpose of the Community Health Roundtable meetings, participants were asked to address in their conversations the question, "**What can you do to improve health in the community?**" At the end of two rounds of small group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

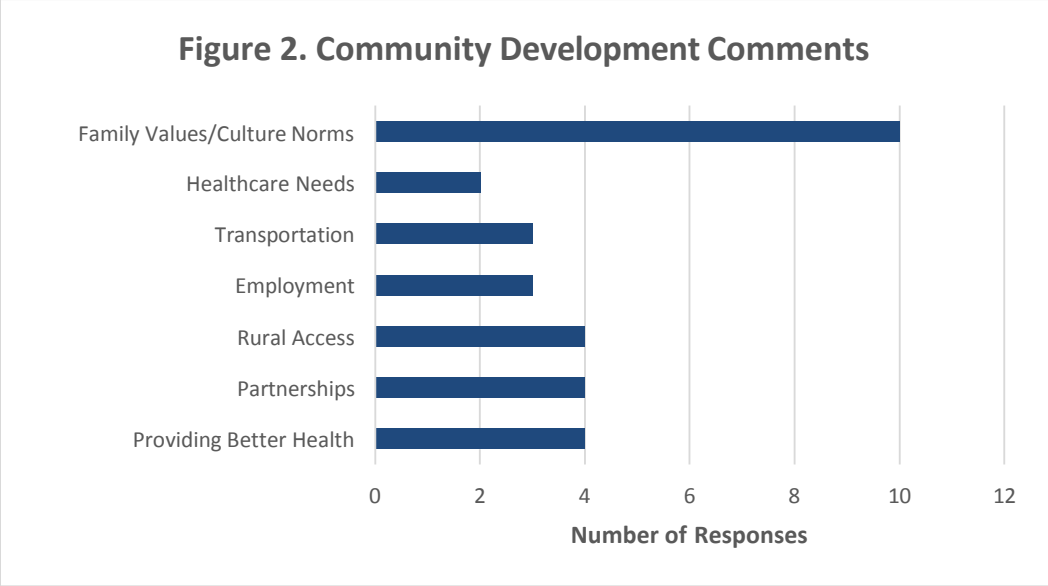
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

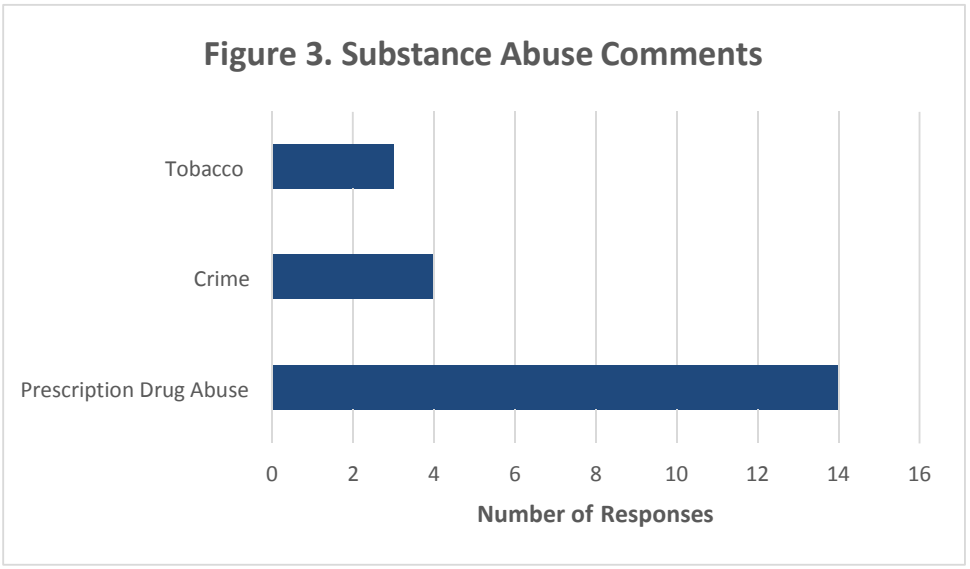
- Community Development
- Substance Abuse
- Nutrition and Physical Activity
- Education

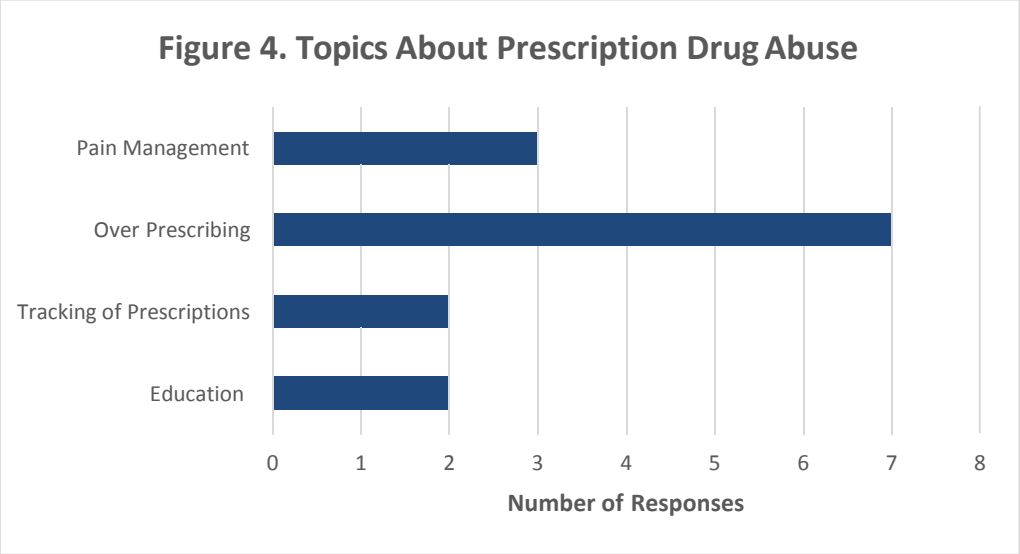


Community Development was characterized by concerns about family values and cultural norms, providing better health information, partnerships, rural access, employment, transportation and health care needs. Figure 2 displays the rate of comments in each of these categories.

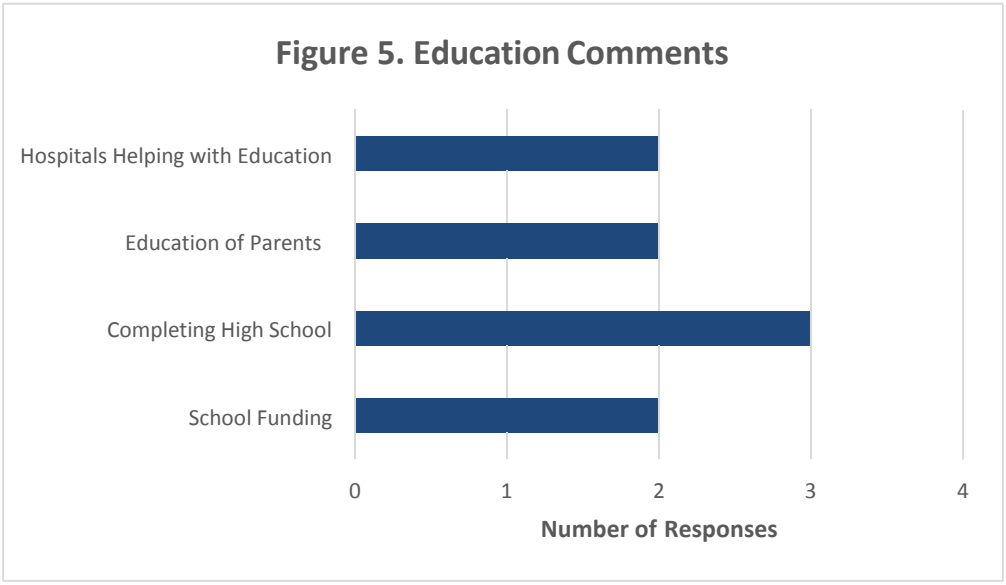


Substance Abuse was the second largest topic of concern among the attendees. Focus areas within this topic included: prescription drug abuse, crime and tobacco. There were several categories related to prescription drug abuse identified from the notes including over prescribing, education, pain management and tracking of prescriptions. Figure 3 shows the distribution of comments around these categories. Figure 4 displays the frequency of comment for each of the topics surrounding prescription drug abuse.

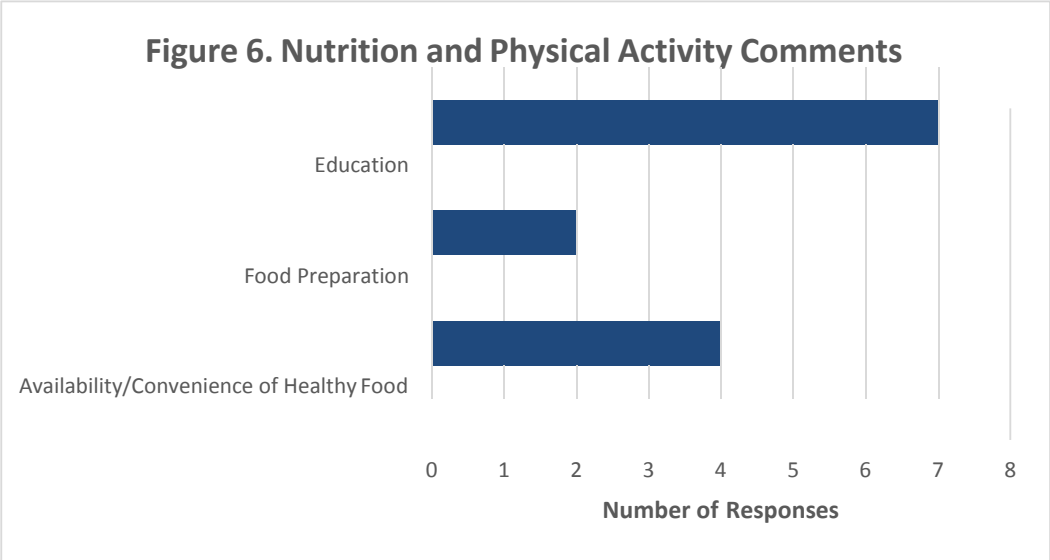




Education is a broad topic that was prevalent within the majority of discussion topics. Ideas specific to the types of education, the targeted age group and setting were included in this major topic. Subgroups within the topic were partnerships, communication, high school completion and education of parents. Participants indicated the need for increased resources, education outside of the schools and collaborative school system infrastructures. Figure 5 displays comment frequencies within the subgroups.



Nutrition and Physical Activity was a prominent concern among the meeting participants. Participants indicated a need for nutrition education and physical activity in the schools, as well as the need for convenience and increased availability of healthy food. Sub-categories developed for this summary analysis include education, availability/convenience of healthy foods and food preparation. Figure 6 displays comment frequencies for these subgroups.



Record of Community Stakeholder and Consumer Views

of the Proposed Cooperative Agreement

ATTACHMENT F

Southwest Virginia 2020 Summit Report


health
care
programs
community
healthy
Community
education
trauma
wellness
data
needs
people
Promote
food
nutrition
Medicaid
access
work
services
support
children
family
school
Education
treatment
change
addiction
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Mental
mental
physical
Health
ACE
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need
schools
resilience
families
group
Collect
together
hard
poverty
aspect
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dental
systems
Root
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system
etc
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Workforce
screening
onsite
generational
Medical
childhood
Increase
things
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child
affordable
help
gym
business
home
recovery
public
exercise
serve
gardens
educate
abuse
activities
kids
traumas
communities
substance
free
sectors
SNAP
recreation
folks
focus
residential
markets
ACEs
perceptions
events
day
Transportation
Affordable
farmers
Nutrition
fitness
place
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different
incentives
term
activity
informed
Lack
prevention
Develop
entities
WIC
based
market
businesses
culture
Building
mobile
hours
act
Access
Reduce
coordination
foods
Expansion
accept
approach
expansion
Trauma
Improve
VA
government
parents
medical
Services
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levels
head
partners
focused
meeting
connected
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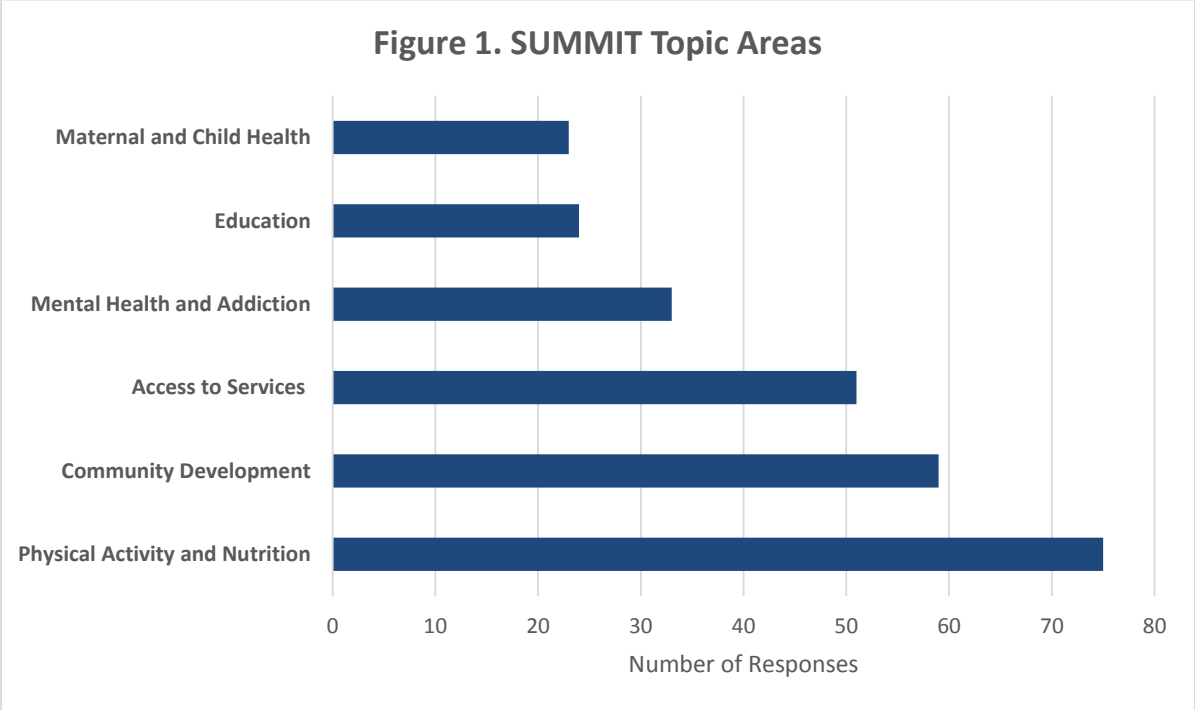
Employer
offer
new
approach
just
opted

During the Southwest 2020 SUMMIT, 65 attendees participated in a World Café style discussion around the question, "**What can you do to improve health in the community?**" At the end of group discussion, notes were collected from the table moderators, or "Table Hosts," to be used for a final large group discussion to allow for further comment and clarification. These notes have been collated and analyzed with the results presented below.

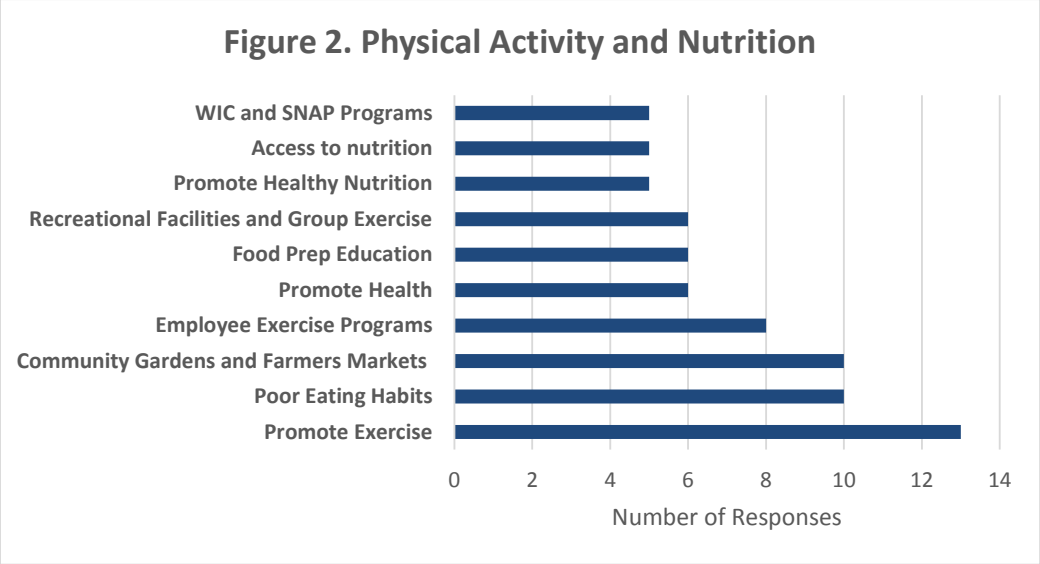
Main Topics of Discussion

These are major categories of discussion among the participants, within which several sub-categories were identified.

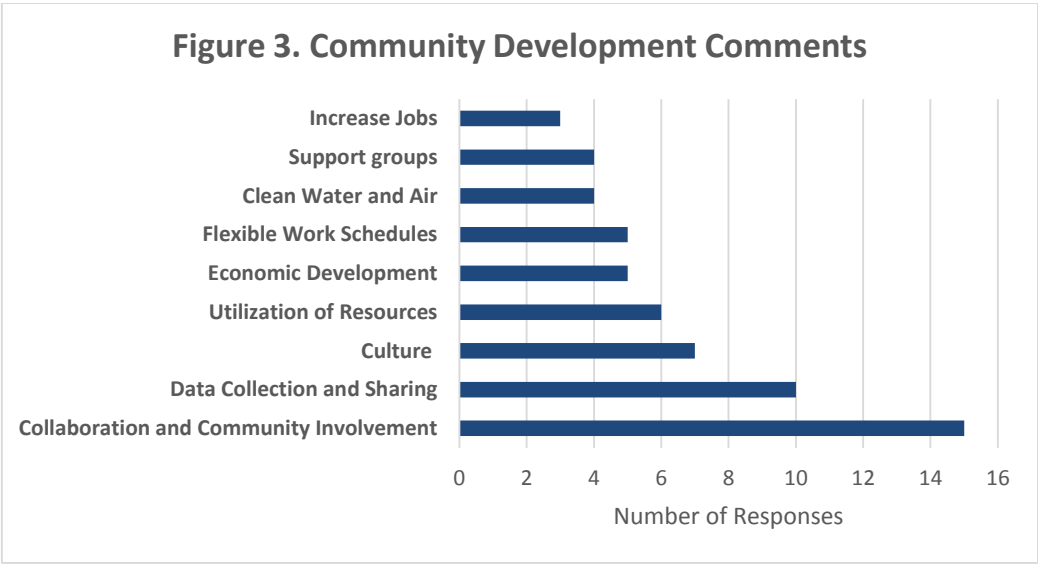
- Physical Activity and Nutrition
- Community Development
- Access to Services
- Mental Health and Addiction
- Education
- Maternal and Child Health



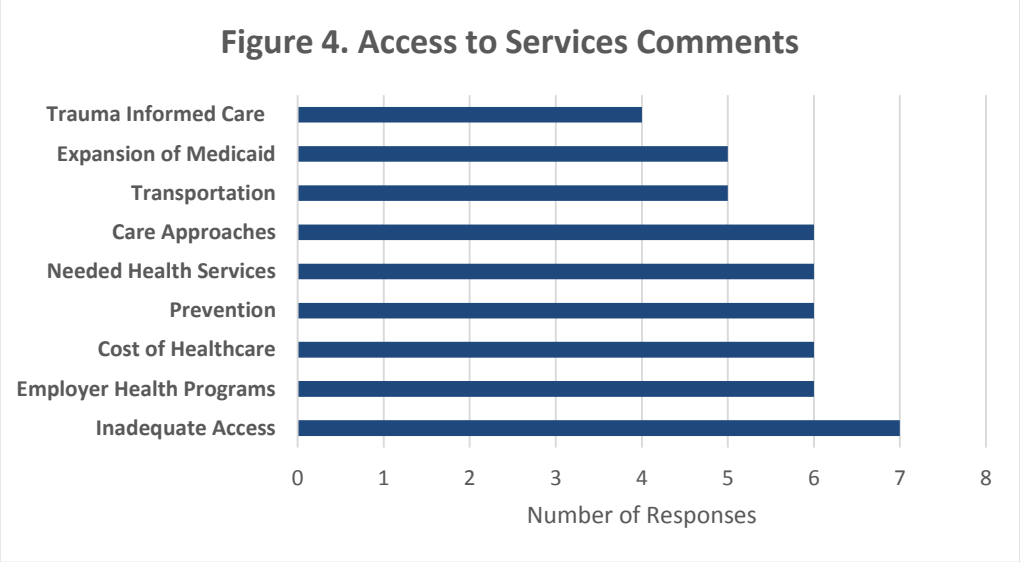
Nutrition and Physical Activity was the most talked about topic during the discussion. Folks indicated a concern about promoting exercise, poor eating habits, increasing community gardens and farmer's markets, employee exercise programs, promoting health and food prep education. There was also mentioned a need for recreational facilities and group exercise, promoting healthy nutrition, access to nutrition and WIC and SNAP Programs. Figure 2 displays comment frequencies for these subgroups.



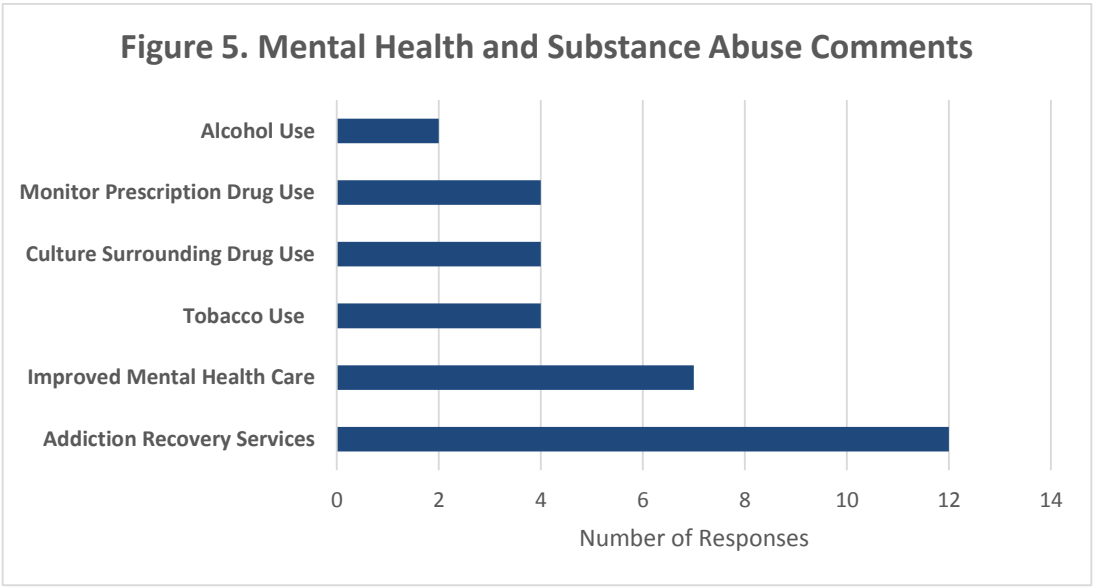
Community Development was the second largest topic of concern among the attendees. In order to identify specific categories within the discussion around community development, comments were broken out and considered individually. Topics under community development included collaboration and community involvement, data collection and sharing, culture, use of resources and economic development. Other topics included flexible work schedules, clean water and air, support groups and increasing jobs. Figure 3 illustrates the comment distribution within this topic.



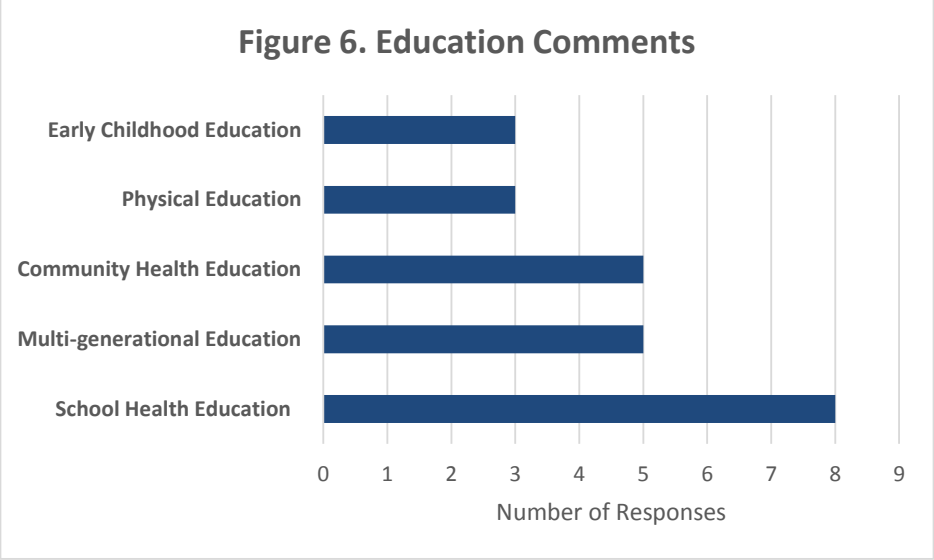
Access to Services was a broad topic that was prevalent within every major discussion topic. Subgroups within the topic were the issues of inadequate access, employer health programs, cost of health care, prevention, needed health services, care approaches, transportation, expansion of Medicaid and trauma informed care. Participants indicated the lack of transportation to health services. Figure 4 displays comment frequencies within the subgroups.



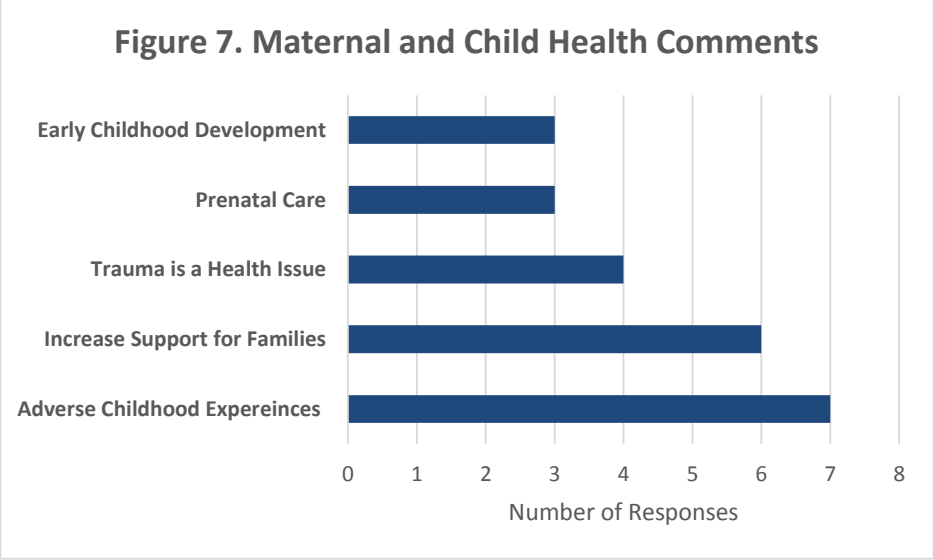
Mental Health and Substance Abuse was a widespread topic. Subgroups within the topic included: addiction recovery services, improved mental health care, tobacco use, culture surrounding drug use, monitoring prescription drug use and alcohol use. Figure 5 shows the distribution of comments around these categories.



Education was a prominent concern among the meeting participants. Participants indicated a need for school health education, multi-generational education, community health education, physical education and early childhood education. During discussion school health education had more comments. Figure 6 displays comment frequencies for these subgroups.



Maternal and Child Health discussions were centered in large part around Adverse Childhood Experiences (ACEs). Topics included: adverse childhood experiences, increase support for families, trauma being a health issue, prenatal care and early childhood development. Figure 7 shows the distribution of comments around these categories.



Record of Community Stakeholder and Consumer Views

of the Proposed Cooperative Agreement

ATTACHMENT G

Community Letters of Support

Bank of Tennessee

July 27, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner Dreyzehner:

As we move into the Regulatory approval of the merger of the Wellmont Health Organization and the Mountain States Health Alliance, I am delighted to have the opportunity to write a letter recommending the COPA approval of this amazing opportunity. Our bank, Bank of Tennessee, is the largest commercial bank between Roanoke and Knoxville so we're right in the heart of the footprint of where the two hospital organizations are located. This gives us an incredibly sensitive feel for what goes on in this area, as you can imagine.

As an outsider looking in at the functioning hospital organization in Northeast Tennessee and Southwest Virginia, it is a paradox to examine the combination of Wellmont back in 1996 when Kingsport and Bristol united to form the Wellmont Health Organization. Obviously, there were doubters that did not think this was a good idea; history proved them wrong. The Wellmont Health Organization became a very strong, high-quality, efficient hospital group that we are all proud of. Through the years, competition between Johnson City's Mountain States Health Alliance and Wellmont sadly created unnecessary competition and a strain between the major three cities in this region, Kingsport, Bristol and Johnson City. With the two boards of each health organization having signed a term sheet, the region of Southwest Virginia and Northeast Tennessee now has the opportunity and vision to become one of the outstanding hospital groups in the nation.

Just across the mountain an hour from us in Asheville, North Carolina, in 1995 a COPA was issued by the State of North Carolina for the combination of Mission Hospital and St. Joseph Hospital (now called Mission Hospital) to move forward. Since that time, the quality of medicine has continued to improve. Today Mission Hospital is honored to be one of the top 100 health organizations in America for the fifth consecutive year. The cost to the patient

P.O. Box 4980 • Johnson City, Tennessee 37602-4980
Toll Free: (866) 378.9500 • www.bankoftennessee.com

at Mission Hospital has risen at a slower rate than competitive costs across the State of North Carolina. If every hospital in the United States performed at the level of Mission Hospital (and we expect the new combination in Northeast Tennessee and Southwest Virginia to perform at this level) then:

- More than 164,000 additional patients would survive each year in this country
- Nearly 82,000 additional patients could be complication free
- The average patient stay would decrease one-half day across the country
- Six billion dollars would be saved in this country

THE ABOVE COMMENTS ARE BASED ON THE ANALYSIS OF MEDICARE INPATIENTS OVER ONE YEAR.

Probably one of the two most important issues that would be addressed (other than quality of healthcare) would be the containment of reasonable cost of healthcare. With the combination of the two hospitals:

- We would have nearly two billion in revenues; if our hospitals were located anywhere else in the country, we'd be closer to a three billion dollar system. Our revenues are strained by the Medicare Wage Index being so low here in our area.
- The system would have one billion dollars in cash
- The operating margins already at AA bond level ratings
- The system would have $1.5 billion in debt with a system that has one billion dollars in cash
- The system would have $225 million dollars per year in re-occurring cash flow

The reason I set this out, obviously as a banker, is cost containment is so important and necessary for the COPA to fulfill its mission.

The best reason to start this organization as a combination is to make meaning; to create a product or service to make our world in Northeast Tennessee and Southwest Virginia a better place to live. That's what this is all about.

Sincerely yours,

W. B. Greene, Jr.
Chairman
BancTenn Corporation

WBGJr/dba

cc: General Herbert Slatery III
Elliott Moore
Andy Hall

First Baptist Church

200 West Church Circle • Kingsport, Tennessee 37660
Telephone (423) 247-4122 • Fax (423) 247-4130 • web-site: fbckpt.net

Dr. Marvin G. Cameron
Pastor
mcameron@fbckpt.net

September 2, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Mr. Dreyzehner:

I am writing to offer my support of the proposed merger between Wellmont Health System and Mountain States Health Alliance. I write as one who visits numerous hospitals in our region at least weekly in my role as a minister. I am honored to serve as Pastor of the First Baptist Church of Kingsport, Tennessee, where I began work in 2001. Our church is as old as our city! Both were constituted in 1917, but we are actually three months older than our government.

I believe the proposed merger is beneficial to our region because it gives the greatest opportunity for local control of the health care of our region. Our region suffers from some of the most challenging health issues in the state. I fear that outside control could lead to diminished response to the acute needs of this region.

My interest in this merger arises from the challenges we face in recruiting and retaining the best caregivers our region demands. I am also aware of the unique financial challenges facing health care in our region due to our Medicare index, the demographics of our region and the financial hardship of many of our citizens.

The proposed merger allows the two systems to occupy a unique place in the life of our region. The synergy provided by their mutual connection to the Quillen School of Medicine will give our region a needed boost in economic development and the ability to make a difference in the lives of our people.

I am fortunate to know personally many of the leaders of both health care systems. I know them as people of integrity who care deeply for our region and our people. I also know the investment of time, energy and

resources they have given to their mutual endeavors to remain independent. They have arrived at the best decision for the people of our region through the proposed merger and I am happy to support it.

Thank you for your work on behalf of the people of Tennessee. If I may be of assistance to you through the COPA process, please feel free to contact me at this address.

Sincerely,

Marvin Cameron, Pastor

CC: General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville TN 37202-0207

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

August 28, 2015

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Dory Creech, Vice Chair
Lynn Tully, Secretary
Troy Clark, Treasurer
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Perry Stuckey
Lynn Tully
Debbie Davis Waltermire
Amy Wenk
David Woodmansee
Jubal Yennie

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Dr. Dreyzehner,

I am writing this letter in support of the integration of the Wellmont and Mountain States Health Systems into a single health system.

The Greater Kingsport Family YMCA is a 501(c)3 not-for-profit organization serving the greater Kingsport area of northeast Tennessee. We started out serving youth and families, meeting child care and youth development needs. Recently, as you know, we have taken on a new role in being a community resource for healthy living—we support over 18,000 members in their efforts to make healthy choices. We are doing that through our youth programs (child care and day camp supporting families), in our facility, and through community efforts like Healthy Kingsport. The YMCA's Diabetes Prevention Program has allowed us to begin targeting a specific population that has a likelihood of becoming Type II Diabetic, and greatly reducing their risk. Credible, evidence-based programs like this are indicators of successes taking place in our region, but we need a collective effort of all the pieces working together towards the same measurable goals, to really tackle the chronic disease prevention opportunities.

Reaching that healthy state in our region has many challenges and barriers. Resolving those is not a simple task and will require a process that can address complex issues. I have seen success with the Collective Impact model in various communities around the country, as well as here, through Healthy Kingsport. We are seeing small pockets and evidence of progress, but we need to scale those to a regional effort. I believe that model, on a large scale, is what we need to successfully impact the health of our entire region. Wellmont and Mountain States are both committed to improving the health of our region. However, as competitors, they are not able to function as the neutral "Backbone Organization," a necessary component for a successful Collective Impact model. As they join forces, they will have the opportunity to function as the neutral system supporting all the efforts towards a common goal. As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's. They will also have an opportunity to unite all the organizations in all our communities to do the same.

YMCA Wellmont Center
Greater Kingsport Family YMCA
1840 Meadowview Pkwy, Kingsport, TN 37660
P 423 247 9622 **F** 423 578 2199
www.ymcakpt.org

YMCA Mission:
To put Christian principles into practice through programs that build healthy spirit, mind, and body for all.

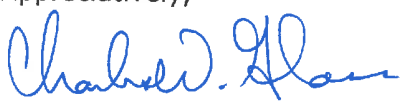
The combined system with expanded resources and a larger footprint will create a new opportunity and potential for real and measurable success. Combined with East Tennessee State University and the vast array of resources available through the university and the medical school, we will have access to one of, if not, the best network and system in the country to really move the needle towards creating a healthy region.

In addition to population health challenges, the health care environment is a challenge itself, particularly for small hospitals and systems. In order for one to survive in today's reimbursement environment, it is necessary to maximize resources, financial as well as human. From purchasing, to electronic health records, to regulations, to recruiting, to specialty areas, to basic care, duplicating efforts to deal with them is not productive. The proposed merger between Mountain States Health Alliance and Wellmont Health System is a response to these challenges, and an opportunity to change the way our local health care providers are able to work together to tackle the health care challenges affecting our region. This will be an opportunity for the two organizations to come together and build something brand new, in a cost-effective manner that reflects what this community really needs – today and in the years ahead.

I support this proposed merger because I believe that together, Wellmont and Mountain States will have the opportunity to truly impact the way health care is delivered in our region. They will have the opportunity—and I believe they will pursue it—to lead the communities they serve, and the organizations in them, in addressing health and health care issues with a multitude of solutions towards a common goal. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community.

I care deeply about this region and our future, as do you, and I know you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come. Thank you for your consideration and for all of your work towards improving the health of all Tennesseans.

Appreciatively,



Charles W. Glass, CEO
Greater Kingsport Family YMCA

cc: General Herbert Slatery III

AEP - Appalachian Power
420 Riverport Road
Kingsport, TN 37660

August 24, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

RE: Proposed Merger of the Wellmont and Mountain States Health Alliance Systems

Dear Commissioner Dreyzehner:

I am the District Manager for Appalachian Power Company's Kingsport District which provides electric distribution services to 47,000 customers in Northeast Tennessee and over 100,000 customers in Southwest Virginia. Appalachian Power is a subsidiary of American Electric Power; we are an investor owned electric utility and are regulated in Tennessee by the Tennessee Regulatory Authority. I have worked in the utility industry for 38 years and have worked for regulated investor owned utilities for most of those years.

The cost of health care and health insurance is becoming one of the biggest concerns to our employees and their families. Appalachian Power employs over 200 employees directly in the area served by my district and another 70 contract workers. Wellmont and Mountain States Health Alliance are the regional health services providers for most of that area.

As the manager of a regulated utility, I have come to understand very well the relationship between investment in facilities to serve the customers we serve and the rates they pay for our product. For my portion of the utility, any investment we make must be paid for by the customers in my part of the world so I have looked on with concern as the two health systems have, over a number of years, matched and have attempted to one up each other with investments in new facilities and new technologies. I become concerned when I think about the cost of those investments and consider the impact investments of that magnitude might have on the rates of the customers I serve as the footprint of the two health systems matches the footprint of my service territory.

There is no doubt that investments in new technologies and new facilities are necessary to provide the healthcare the region needs, but investment in duplicated facilities and technologies just for the sake of competition makes very little sense. My years of working in a regulated environment have disciplined my thinking so I make necessary investments but reject quickly investments that over-reach and are just not prudent. In our world, our regulators can and do deny recovery for imprudent investments so we continuously scrutinize our plans and avoid over-building and over-staffing; this effort keeps our costs and our customers' rates low.

I see nothing but good in the merger of the two systems and the oversight of their operations by the states of Tennessee and Virginia. I believe the combination of the systems will continue to provide the citizens of this region with the best healthcare while improving the cost profile of the combined system saving its citizens millions of dollars. I urge you to approve the Certificate of Public Advantage so this most needed merger can move forward.

Isaac J. Webb
District Manager
AEP – Appalachian Power

C: General Herbert Slatery III

HEALTHSOUTH
Rehabilitation Hospital

August 11, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Commissioner Dreyzehner,

I am CEO at HealthSouth Rehabilitation Hospital in Kingsport, TN. In my 22 years of experience in healthcare administration, there has never been a time of greater change in health care – both locally in our region and across the U.S. Sweeping changes have been and will continue to occur for our nation's hospitals, physicians and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it. When my 150 employees or their dependents need acute healthcare services, they receive that care at either Wellmont Health System or Mountain States Health Alliance.

I am concerned about the industry challenges that hospitals are facing and in particular the two health systems, Wellmont Health System or Mountain States Health Alliance, that care for myself, my family, and my employees. These challenges include increasing reimbursement cuts in a market that already has one of if not the lowest Medicare reimbursements in the Nation, declining inpatient volumes, constrained revenue, and increasing difficulty in recruiting and retaining physicians.

The proposed merger between Mountain States Health Alliance and Wellmont Health System is a response to these challenges, and an opportunity to change the way our local health care providers are able to work together to tackle the health care challenges affecting our region. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all. While no solution can perfectly address the mounting headwinds facing our national healthcare providers, I believe this proposed merger is right for our region.

The significant advantages I see include better coordinated care though a unified electronic health record. The proposed merger's ability to recruit and retain the best and brightest physicians through cooperation and coordination with East Tennessee State University and the

Quillen College of Medicine is paramount to addressing the serious health issues in our region. Finally, enhance needed services, like substance abuse and mental health which is going largely untreated and relegated to only reactionary treatment from our crowded emergency rooms.

I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community. Please give your thoughtful consideration to the benefits this proposed merger will bring to our region.

Sincerely,

Troy Clark

Troy Clark, MSHA, MBA, FACHE
Chief Executive Officer
HealthSouth Rehabilitation Hospital

Cc: General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207 Nashville, TN 37202-0207

GRC
Construction
130 Regional Park Dr. • Kingsport, TN 37660 • (423) 349-7760 • www.grcinc.com

August 11, 2015

Department of Health
ATTN: Commissioner John Dreyzehner
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner John Dreyzehner,

Goins Rash Cain Construction, Inc. proudly supports the proposed merger between Mountain States Health Alliance and Wellmont Health System. Since 1988, Goins Rash Cain Construction, Inc. has been responsible for over one billion dollars of building construction. As a successful construction company for over 27 years, we provide personalized, responsive service to each client. We employ the latest technology and implement consistent construction procedures at the best cost. As a company who thrives on helping our community grow, we are hoping to see our health care opportunities expand in this region.

We, as a company, would not be successful if it were not for our valued employees and clients. Goins Rash Cain Construction wants our community to be provided with the best healthcare possible. With our local healthcare providers teaming up, we believe our region will be able to tackle any health care challenges we face. There are many serious health issues that need to be addressed in our region. Cardiovascular disease, diabetes, pulmonary disease, addiction, and untreated mental illness burden our region. With Mountain States Health Alliance and Wellmont Health System merging, this will allow us to have better access to health care.

Goins Rash Cain deeply cares about this region and its future. We believe the Mountain States Health Alliance and Wellmont Health System merger is the right step in the direction towards a brighter future for East Tennessee. This health system merger will give a positive impact to our community today and the next generations to come. As a company who thrives on expanding this region, we would like to see this community build a stronger health system.

Sincerely,

Luther Cain, President

CALVIN & LESLIE CLIFTON
[redacted] FIDDLERS WAY ▫ KINGSPORT TN 37664

July 21, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

RE: Statement of Support for the proposed merger of
Wellmont Health System / Mountain States Health Alliance

Commissioner Dreyzehner,

Please accept this letter of support for the proposed merger of our local healthcare providers: Wellmont Health System and Mountain States Health Alliance.

My wife, Leslie, and I are lifelong residents of Northeast Tennessee. We have had the opportunity to live and work in other regions, but we have found that Northeast TN offers the very best of everything that we need to live happy and healthy lives. Our adult children were both born and raised here and share our love for the region.

Quality, local healthcare is one of the things that we, as a region, have simply taken for granted. Both Wellmont and Mountain States have provided the very highest quality healthcare to our family and friends through the years. During the recent decade or so, we have witnessed many changes, growth, and improvements to both organizations. However, in our opinion, the competitive nature of having two major, regional providers has resulted in the repetition of facilities and services.

Our support for this merger is based on *affordability* and *accessibility* of quality healthcare for our family and future generations in the region. We see this merger as the very best option for the future of our region. As someone who cares deeply about this region and our residents, I trust that you will thoughtfully consider all of the benefits that this proposed merger will bring to our region, both today and for future generations.

Thank you for the opportunity to comment and to provide this letter of support for the merger.

Sincerely,

Calvin D. Clifton

cc: General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, TN 37202-0207

Citizens BANK

MEMBER FDIC

www.citizensbank24.com

July 31, 2015

Commissioner John Dreyzehner
Tennessee Department of Health
425 Fifth Avenue South
Nashville, Tennessee 37243

Dear Commissioner Dreyzehner:

Since its founding in 1934, an optimistic vision of the future for the Tri-Cities region is virtually synonymous with the Citizens Bank name. Today, Citizens Bank operates as a locally-owned, tax-paying small business helping other local individuals, businesses and organizations succeed by providing lending, deposit and investment services. Citizens Bank literally invests in the future of the Tri-Cities region.

In addition, our bank's executives and staff have devoted countless hours to improving the community through participating in boards and decision-making bodies, guiding civic projects, volunteering in the community and donating thousands of dollars to local and regional causes.

Our commitment to the region runs deep, which is why I am writing in support of the merger between Wellmont Health System and Mountain States Health Alliance.

Despite the progress in treating diseases, East Tennessee continues to face significant challenges when it comes to the health of the local population. Cardiovascular disease, diabetes, pulmonary disease, addiction and untreated mental illness are just some of the major afflictions impacting healthcare in our region. In addition, local hospitals face significant challenges in delivering high quality service with the threat of declining revenues.

The proposed merger between Wellmont and Mountain States is a local solution to a complex problem. By combing resources directed towards a common purpose, reducing overhead costs and expanding access to services, the combined organization stands to truly impact the way healthcare is delivered in our region.

This merger stands to benefit the region in innumerable ways, but we are most excited about how it will contribute to attracting and retaining medical talent, enhancing medical services and improving quality access to healthcare at the lowest possible cost.

Like our passion, we believe the proposed merger between Wellmont and Mountain States presents an optimistic vision for the future and we encourage you to approve this request.

Sincerely,

Joe LaPorte, III
Chairman & CEO

Bill Dudney
President

cc: General Herbert Slatery III
Office of the Attorney General and Reporter
P. O. Box 20207
Nashville, Tennessee 37202-0207

BRISTOL
P.O. Box 1218
Bristol, TN 37621-1218
423-989-4400
Fax 423-989-4445

ELIZABETHTON
P.O. Box 1900
Elizabethton, TN 37644-1900
423-543-2265
Fax 423-543-7400

JOHNSON CITY
P.O. Box 1265
Johnson City, TN 37605-1265
423-952-2265
Fax 423-854-9085

KINGSPORT
P.O. Box 687
Kingsport, TN 37662-0687
423-245-2265
Fax 423-378-0415

CHRIS MULLINS CO., L.L.C.
ACOUSTICAL CEILINGS • INSULATION

October 15, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

RE: Proposed Merger of Wellmont Health System and Mountain States Health Alliance

Dear Commissioner Dreyzehner:

I am writing this letter as the Chief Manager of an Acoustical Ceiling and Insulation subcontracting firm that has been in business in Kingsport, Tennessee since 1949. My father started this business and I now have two sons in the business with me. We currently have 30 employees.

As a family that has lived in Kingsport all of our lives, we are committed to this region and want our health care system to be the very best that it can be not only for our own family but for our employees and all citizens of this area. We do offer health insurance to our full-time employees but premiums are very high and difficult for many to afford. Affordability seems to be the biggest challenge for all of us.

We want our employees to be able to receive the best care that is available and feel that merging Wellmont and Mountain States under the COPA statue will benefit all of us greatly. We need a health system in place to work for all of us.

Sincerely,

Chris L. Mullins
Chief Manager

cc: General Herbert Slatery III
Office of the Attorney General & Reporter
P. O,. Box 20207
Nashville, TN 37202-0207

200 LYNN GARDEN DRIVE • KINGSPORT, TENNESSEE 37660 • PHONE (423) 378-3737 • FAX 378-6132

Mike McIntire
[redacted] Pendleton Place
Kingsport, TN 27664
November 2, 2015

Commissioner Dreyzehner
Department of Health
425 Fifth Avenue North
Nashville, Tennessee 37243

Dear Commissioner Dreyzehner:

Re: Support for Merger of Wellmont and Mountain State Health Systems

I am a long-term resident of Kingsport and current serve our city as Vice Mayor. My wife and I have had the need to utilize the services provided by both health systems and have always been pleased with the service and the outcome. I want to express my strong support for the merger of these two systems and to briefly state why I think this merger is in the best interests of the citizens in our region.

My support is based on the following:

- I recognize that the complex financial strains on the health care system are placing extreme pressure on all health care systems and controlling costs are essential to survival. Consolidations and mergers are the most obvious ways to achieve cost savings. Merger of our two local systems provides these cost savings while maintaining control of our hospitals in the region and their focus on the unique health needs. This has the highest probability of assuring high quality medical services that our communities need.
- While consolidation will likely result in some job reductions in some areas, the two systems together should be able to offer better medical services overall and should also be able to have sufficient patient load to add some subspecialty care which now requires patients to travel to larger systems.
- The combined system should be able to bring better focus on major health issues in our region including substance abuse, mental health, heart disease, diabetes, and obesity and help assure that our next generation is healthier than the current one.
- Concerns about monopolistic issues are largely unfounded because prices are controlled by the Federal government (Medicare and Medicaid) and insurance companies. I can see no reason that a merged health system could charge higher prices for medical services.
- Because of a significantly larger health care system, the opportunity to expand medical related work with East Tennessee State University to tackle public health issues in our region is an added bonus to the merger and one that has not only improved health implications but also economic development opportunities in the medical field in the region.

I believe these factors strongly favor your approval of the merger of Mountain State Health Alliance and Wellmont Health System and I strongly recommend your approval.

Sincerely,

Mike McIntire

EASTMAN CREDIT UNION®

PO Box 1989
Kingsport, TN 37662

Phone: 423.229.8200
or 800.999.2328

November 3, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner Dreyzehner:

My name is Olan Jones and I am the CEO/President of Eastman Credit Union (ECU). Founded in 1934 and headquartered in Kingsport, Tennessee, ECU is the largest credit union in TN and one of the 50th largest credit unions in the U.S. employing over 600 individuals. As a not-for-profit organization, ECU is a strong supporter of the communities we serve.

The purpose of this letter is to let you know that I support the proposed merger of Wellmont Health System and Mountain States Health Alliance.

We all know there has never been a time of greater change in health care - both locally in our region, as well as across the U.S. Significant changes have been and will continue to occur for our nation's hospitals, physicians and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it.

Additionally, there are significant challenges facing our region:

- **Industry Challenges for Hospitals:** These include increasing reimbursement cuts, declining inpatient volumes, constrained revenue, and increasing difficulty in recruiting and retaining physicians.
- **Regional Health Issues:** Serious health issues in our region that need to be addressed include cardiovascular disease, diabetes, pulmonary disease, addiction and untreated mental illness – and the cost of this poor health is not sustainable. Additional factors unique to our region include the rural nature of many hospitals and the need to expand investment in research and physician training programs.

The proposed merger between Wellmont and Mountain States is a response to these challenges, and an opportunity to change the way our local health care providers work together to tackle the health care challenges affecting our region. This will be an opportunity for the two organizations to come together and build a new organization, one that reflects what this community needs – today and in the years to come.

As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all.

EASTMAN CREDIT UNION®

PO Box 1989
Kingsport, TN 37662

Phone: 423.229.8200
or 800.999.2328

In Tennessee, the two organizations are pursing approval under the COPA (Certificate of Public Advantage) statute. Under a COPA agreement, our region's employers, patients and payors will be protected. State supervision will ensure the future combined organization will continue to benefit the community by providing health care that is affordable, accessible, cost-efficient and most importantly, high-quality.

This local solution to our region's health care challenges is far better scenario than other partnerships Wellmont and Mountain States have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

Growing up in Kingsport, I learned the value of community; the value of people working together for the greater good. It was because of these community values that I chose to raise my family in this community, base my entire professional career in this community, and serve on a number of committees, boards and project teams in this community. I believe, together, Wellmont and Mountain States can collaborate to truly impact the way health care is delivered in our region. I hope you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

With kind regard,

Olan Jones
CEO/President

cc: General Herbert Slatery III

ECU BESIDE YOU
www.ecu.org

Healing Hands
Health Center

245 Midway Medical Park
Bristol, Tennessee 37620
www.healinghandshealthcenter.org

September 28, 2015

Commissioner John Dreyzhner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Dr. Dreyzhner,

Healing Hands Health Center would like to offer its support for the proposed merger between Wellmont Health System and Mountain States Health Alliance. The work of these two hospital systems and their dedicated staff provides health care services to many residents who, without them, would have limited access to care. Like both groups, Healing Hands works to serve the residents of Southwest Virginia and Northeast Tennessee. Since 1997, we've been able to provide more than 65,000 charitable medical, dental, vision, chiropractic and counseling services to the hard-working, uninsured individuals on Northeast Tennessee and Southwest Virginia. We work hard to keep people out of the Emergency Department and helping them live happier and healthier lives.

We understand the role and impact the merger would have on our community in expanding access to services to those in our area. We recognize that as a combined organization, Wellmont and Mountain States can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all.

Each community organization has its role, and that shared responsibility and willingness to work together has served to improve the overall well-being of the population. Expanded access to health care has long been a need in the area and a goal of community leaders and safety net partners. With this project, Wellmont and Mountain States will be able to provide patients with much needed access to high-quality care. Again, we believe this model of service integration will also maximize efficiency and contain costs, while improving health outcomes via a coordinated, inter-disciplinary treatment plan.

Healing Hands Health Center is proud to support this proposed merger because we believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region; of which we will all benefit. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

If you need more information, please feel free to contact me at (423) 652-2516.

Sincerely,

Helen

Helen Scott
Executive Director

1005 Glenway Avenue
Bristol, Virginia 24201-3473
(276) 466-3322

The United Company

November 11, 2015

Commissioner John Dreyzehner
Tennessee Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

RE: Proposed Merger of Wellmont Health System and Mountain States Health Alliance

Dear Commissioner Dreyzehner:

The United Company, a diversified private investment company, is a long standing corporate citizen of the region with many of our employees working and living here. In addition to my duties at the Company, I serve as a member of the Board of Directors for Bristol Regional Medical Center and a member of the Population Health and Healthy Communities Steering Committee, a committee established jointly by Wellmont Health System and Mountain States Health Alliance to discuss the area's largest healthcare challenges and how best they can be addressed on a regional basis. We have several challenges and it will take outside-of-the-box solutions to help the region advance the quality of care needed.

A certificate of public advantage is deliberate in its attempt to provide the ability for uniquely positioned health care systems to come together under regulation and supervision from the state. It is my view that a certificate of public advantage provides an opportunity for this region to take an important step forward in ensuring quality, comprehensive and affordable health care. As you are aware, in accordance with the law, appropriate state officials will continue to act in an oversight capacity ensuring action taken is consistent with sound health care policy. Once approved and implemented, I would encourage you to help ensure steady cost monitoring and enforcement, but retain the ability for the proposed new health system to be nimble in meeting our population health needs.

I have heard, and understand in theory, concerns that have been raised by a few regarding reduced competition. As an employer who provides a self-funded insurance plan for our full-time employees, we appreciate efforts to keep quality healthcare affordable. However, as you know the proper evaluation to be made is not will there be less competition, but whether the benefits likely to result from a proposed cooperative agreement outweigh the disadvantages likely to result from that reduced competition. It is here, looking at the benefits to be considered, including affordability, where I believe the scales tip clearly in favor of a carefully structured, and appropriately regulated, cooperative agreement.

One example cited, Mission Health System in Asheville, North Carolina, a community within a two hour drive of much of this region and with many similarities to it, appears to have operated for years under a certificate of public advantage. It is my understanding that costs have risen at a lower rate than most of the nation and the system has been ranked by some near the very top of all healthcare providers across the country on clinical quality and efficiency. As healthcare policy continues to evolve in the years ahead, a strong system with the resources and experience needed to understand and tackle our unique needs will be critical.

Bottom line, given our unique needs the status quo is not getting us where we all collectively believe we need to go. However, through this proposed merger and within the proper regulatory environment we believe we can get there. Thank you for your important work on this initiative.

Sincerely,

Martin L. Kent
President and Chief Operating Officer

cc: The Honorable Herbert H. Slatery III, Tennessee Attorney General and Reporter

November 12, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

CC: General Herbert Slating III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, TN

Dear Commissioner Dreyzehner,

I am writing in support of the proposed merger between Wellmont Health System and Mountain States Health System in North East Tennessee. For most of my adult life I have been directly or indirectly involved in health care issues. My husband has practiced pediatrics in the Kingsport area for the past 48 years. I have served on the Holston Valley Medical Center Board of Directors for 12 plus years and served as Chair of the Board that also placed me on the Wellmont System Board of Directors. For six years I served as Mayor of the City of Kingsport where the well-being of our employees was a major concern. I've been an advocate for health and wellness issues in a professional and volunteer capacity and currently serve on the Advisory Council for Healthy Kingsport, a partner with the Healthy Tennessee initiative.

It has been well documented that the health status of our region needs to be improved. We have serious health care problems in the area of diabetes, cardiovascular disease, substance abuse and obesity. It is my strong believe that we can address these and other health care issues more effectively with a combined health care system. With the elimination of competing efforts, serious overlap of services and with our combined scarce resources directed at these regional problems we can expect better outcomes and begin to see improvements in the health status of our citizens.

Also, in this ever changing health care climate in which we find ourselves, a combined system will be able to improve access to much needed services for our citizens. We believe working together will create a stronger force than working separately. Our region is simply too small to support two competing health care systems. I am excited about the possibilities that a merger holds for our region. Together we will be working to make our next generation healthier than today's and to make sure those who need health care services can access the best care available in the nation.

Sincerely,

Jeanette D. Blazier
Former Mayor, City of Kingsport, Tennessee

CUSTOMER 1 ONE, INC.
Bill Gatton
CHEVROLET Cadillac ISUZU
1000 West State Street • Bristol, Tennessee 37620 • (423) 764 5121 • www.billgatton.com

November 18, 2015

Commissioner John Dreyzehner
Dept. of Health
425 5th Ave. North
Nashville, TN 37243

Commissioner Dreyzehner,

I am writing to you in regards to the proposed merger of Mountain States Health Alliance and Wellmont Health System

Our organization, Bill Gatton Automotive Group, employs 150 individuals in the Tri-Cities area of Tennessee and Southwest Virginia. Additionally we have physical operations in both states and have provided automotive services to this region for over 47 years.

We, as with most businesses, are very concerned with the cost and quality of available health care for our employees and customers. We live in a region where cardiovascular disease, obesity and drug abuse are major health challenges. Through this proposed merger and collaboration with East Tennessee State University along with Quillen College of Medicine and the Bill Gatton College of Pharmacy, we believe an informed and educated populace can change this tide.

Lower costs can be obtained by eliminating the duplication of services and technology these two health systems are employing today. We believe cost, through the COPA process, can be controlled by the supervision of the State of Tennessee and the Commonwealth of Virginia.

We fully support this proposed merger as a way to positively impact the way health care is delivered in our area and hope you will thoughtfully consider all of the benefits this merger will bring to our region.

Respectfully yours,

Chris Lee
COO Bill Gatton Automotive Group

cc: General Herbert Slatery III, Office of the Attorney General and Reporter, P.O. 20207, Nashville, TN 37202-0207

John M. Vann

[redacted] Fairway Drive • Bristol, TN 37620
Phone: 423.[redacted] • E-Mail: [redacted]

November 30, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Commissioner Dreyzehner:

It is with tremendous enthusiasm that I write in support of the proposed merger between Wellmont Health System and Mountain States Health System.

I am proud of our region and prouder still of the two very fine health systems in our area. With the changes we have experienced in health care overall, it is incumbent upon systems to seek ways to circumvent the barriers to continued high quality patient care. I believe that Wellmont performed a very thorough search for a qualified merger partner to gain efficiencies while maintaining highest standards of care. The fact that Mountain States was determined to be the partner of choice through this process is a testimony to both systems' strong desire to serve the region for the betterment of all.

Our region is blessed with a wonderful environment in which to work and live. Yet, our region is plagued with chronic health issues that impact the quality of life. The economic condition of the region has also been compromised in recent years. Having faced the challenge of employing nearly 200 professionals and trying to attract talented colleagues to our region, I believe the strength of the merged health system will be a draw not only for physicians who will see the benefits of a unified health system, but for new employees of all businesses and new industries seeking a high quality location – a very important by-product of this process. The combined organization will also capitalize and expand its scope for research and innovative care with the collaboration with ETSU School of Medicine, producing yet another boost to our local and regional economic development efforts.

Uniting the resources of the two systems creates so many opportunities for better access to healthcare and improved service to the public through educational programs on issues that affect the health and wellbeing of families in our area.

These and many more reasons are why I stand in support of the proposed merger. I trust that you and your office have and will continue to affirm this decision as the best for the future of healthcare in our region.

Sincerely,

John M. Vann

CC: General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, TN 37202-0207

Bank of Tennessee

November 18, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner Dreyzehner,

Bank of Tennessee and I have been very involved in the proposed merger of our two health systems headquartered in Johnson City and Kingsport, Tn. Our board recognizes the impact of local ownership and control, of our health care delivery system. Once it became known that Wellmont had essentially put themselves up for sale to an out of town hospital system, we sprang into action to ignite and unite the communities that they serve. Our position was quite clear from the outset. Merge the two hospitals and form a stronger alliance with ETSU. The benefits are numerous in spite of some overlapping jobs that will be eliminated.

We helped facilitate meetings to explain to the public what we stood to gain and what we stood to lose. We also helped with communications between the state governments and other regulatory agencies that will need to deal with the COPA.

In short, Bank of Tennessee is all in for the merger of these two hospital systems and we will help in any way to make it happen.

Thank you for your diligence and consideration in this matter. We believe that our employees, families, extended community and future generations will be much better served this way.

Sincerely,

Roy L. Harmon, Jr.
Chairman and CEO

P.O. Box 4980 • Johnson City, Tennessee 37602-4980
Toll Free: (866) 378.9500 • bankoftennessee.com

Bank of Tennessee

July 27, 2015

Dr. William Hazel, Jr.
Secretary of Health and
Human Resources
P. O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel:

As we move into the Regulatory approval of the merger of the Wellmont Health Organization and the Mountain States Health Alliance, I am delighted to have the opportunity to write a letter recommending the COPA approval of this amazing opportunity. Our bank, Bank of Tennessee, is the largest commercial bank between Roanoke and Knoxville so we're right in the heart of the footprint of where the two hospital organizations are located. This gives us an incredibly sensitive feel for what goes on in this area, as you can imagine.

As an outsider looking in at the functioning hospital organization in Northeast Tennessee and Southwest Virginia, it is a paradox to examine the combination of Wellmont back in 1996 when Kingsport and Bristol united to form the Wellmont Health Organization. Obviously, there were doubters that did not think this was a good idea; history proved them wrong. The Wellmont Health Organization became a very strong, high-quality, efficient hospital group that we are all proud of. Through the years, competition between Johnson City's Mountain States Health Alliance and Wellmont sadly created unnecessary competition and a strain between the major three cities in this region, Kingsport, Bristol and Johnson City. With the two boards of each health organization having signed a term sheet, the region of Southwest Virginia and Northeast Tennessee now has the opportunity and vision to become one of the outstanding hospital groups in the nation.

Just across the mountain an hour from us in Asheville, North Carolina, in 1995 a COPA was issued by the State of North Carolina for the combination of Mission Hospital and St. Joseph Hospital (now called Mission Hospital) to move forward. Since that time, the quality of medicine has continued to improve. Today Mission Hospital is honored to be one of the top 100 health organizations in America for the fifth consecutive year. The cost to the patient

at Mission Hospital has risen at a slower rate than competitive costs across the State of North Carolina. If every hospital in the United States performed at the level of Mission Hospital (and we expect the new combination in Northeast Tennessee and Southwest Virginia to perform at this level) then:

- More than 164,000 additional patients would survive each year in this country
- Nearly 82,000 additional patients could be complication free
- The average patient stay would decrease one-half day across the country
- Six billion dollars would be saved in this country

THE ABOVE COMMENTS ARE BASED ON THE ANALYSIS OF MEDICARE INPATIENTS OVER ONE YEAR.

Probably one of the two most important issues that would be addressed (other than quality of healthcare) would be the containment of reasonable cost of healthcare. With the combination of the two hospitals:

- We would have nearly two billion in revenues; if our hospitals were located anywhere else in the country, we'd be closer to a three billion dollar system. Our revenues are strained by the Medicare Wage Index being so low here in our area.
- The system would have one billion dollars in cash
- The operating margins already at AA bond level ratings
- The system would have $1.5 billion in debt with a system that has one billion dollars in cash
- The system would have $225 million dollars per year in re-occurring cash flow

The reason I set this out, obviously as a banker, is cost containment is so important and necessary for the COPA to fulfill its mission.

The best reason to start this organization as a combination is to make meaning; to create a product or service to make our world in Northeast Tennessee and Southwest Virginia a better place to live. That's what this is all about.

Sincerely yours,

W. B. Greene, Jr.
Chairman
BancTenn Corporation

WBGJr/dba

cc: Attorney General Mark Herring
Elliott Moore
Andy Hall

Ball Construction Co., Inc.

1675 Park Ave.
Norton, Va. 24273
Phone (276) 679-1016
Fax (276) 679-2962

July 21, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P. O. Box 1475
Richmond, Va. 23218

CC: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, Va. 23219

I am writing this letter to address the merger between Wellmont Health System and Mountain States Health Alliance. I am the owner of Ball Construction Co., Inc., located in Norton, Va. We have been in business since 1960 and currently have approximately 25 employees. We are a general contractor doing mostly commercial work.

One of the benefits of our company is that we have made health insurance available to our employees and with the current rising cost of health care, it has been quite a challenge for them and me. As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose -- to make the next generation of this region healthier than today's, and to make sure those who need health care services can access the best care available. By joining together, they could redirect spending away from wasteful duplication that has not added value and invest in efforts to make our region healthier while controlling costs and making health care more affordable for everyone.

As someone who cares about this region and our future, I hope you will consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

Sincerely,

Mike Ball

07/21/2015

Attorney General Mark Herring
900 East Main Street
Richmond, VA 23219

Mr. Herring:

My name is Michael McCool and I am a Vice President and Partner at Cary Street Partners in Abingdon, VA. Cary Street Partners is a Wealth Management and Investment Banking firm based in Richmond, VA. Our practice in based in Abingdon, VA. I am writing this letter in support of the merger between Wellmont Health System and Mountain States Health Alliance.

As you know, there has never been a time of greater change in health care, both locally in our region and across the United States. Sweeping changes have been and will continue to occur for our nation's hospitals, physicians, and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it. In our region specifically, it is of great importance that we have a thriving, economically viable hospital system. Not only do our citizens need and deserve the best care, but also with the downturn in the energy markets, we need the jobs. In our rural area we need to expand investments into the quality and availability of care in all areas. I feel this merger will help achieve that aim. I feel the proposed merger is a response to the challenges that face our area.

As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose, to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access health care that can compete with any other area in the nation. I feel that by coming together these two units can reduce wasteful expense and invest in efforts to make sure our region has access to the best doctors and care, all while making it more affordable to the patient. In closing I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. As a citizen who cares deeply about the present and future of our region, I hope you will consider all of the benefits this proposed merger will bring to our region not only immediately, but for generations to come. Thank you.

Sincerely,

Michael F. McCool
VP/Partner
Cary Street Partners, LLC

Healing Hands
Health Center

245 Midway Medical Park
Bristol, Tennessee 37620
www.healinghandshealthcenter.org

September 28, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
Post Office Box 1475
Richmond, Virginia 23218

Dear Dr. Hazel,

Healing Hands Health Center would like to offer its support for the proposed merger between Wellmont Health System and Mountain States Health Alliance. The work of these two hospital systems and their dedicated staff provides health care services to many residents who, without them, would have limited access to care. Like both groups, Healing Hands works to serve the residents of Southwest Virginia and Northeast Tennessee. Since 1997, we've been able to provide more than 65,000 charitable medical, dental, vision, chiropractic and counseling services to the hard-working, uninsured individuals on Northeast Tennessee and Southwest Virginia. We work hard to keep people out of the Emergency Department and helping them live happier and healthier lives.

We understand the role and impact the merger would have on our community in expanding access to services to those in our area. We recognize that as a combined organization, Wellmont and Mountain States can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all.

Each community organization has its role, and that shared responsibility and willingness to work together has served to improve the overall well-being of the population. Expanded access to health care has long been a need in the area and a goal of community leaders and safety net partners. With this project, Wellmont and Mountain States will be able to provide patients with much needed access to high-quality care. Again, we believe this model of service integration will also maximize efficiency and contain costs, while improving health outcomes via a coordinated, inter-disciplinary treatment plan.

Healing Hands Health Center is proud to support this proposed merger because we believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region; of which we will all benefit. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

If you need more information, please feel free to contact me at (423) 652-2516.

Sincerely,

Helen

Helen Scott
Executive Director

Rebecca C. Coleman

P.O. Box [redacted]

Gate City, VA 24251

Dr. William Hazel Jr.

Secretary of Health and Human Resources

P.O. Box 1475 Richmond, VA 23218

Dear Secretary Hazel:

I am writing to express my support for the proposed merger between Wellmont Health System and Mountain States Health Alliance (MSHA).

As longtime District Director and later Chief of Staff and Senior Advisor to Representative Rick Boucher of Virginia's Ninth Congressional District, I have been all too aware of the increasing difficulty of recruiting and retaining physicians in Southwest Virginia. Further, I have observed over the years with dismay the trend of cutting reimbursements to doctors and hospitals in rural regions such as ours. In Virginia, where the General Assembly has declined to participate in federal Medicaid Expansion, the situation has become dire for our hospitals, as evidenced by the closure of several smaller ones throughout the region.

These factors are among many significant challenges faced by both Systems, and they require development of an approach to containing costs and recruiting qualified medical personnel that is unlikely, if not impossible to achieve in a highly competitive environment. The proposed merger will allow the two systems to avoid wasteful duplication and better coordinate care, while making health care more affordable and enhancing needed services for residents.

In light of the many challenges they are facing, it seems unlikely that either MSHA or Wellmont as a stand-alone institution can continue to provide the high quality, regionwide medical services to which we are accustomed. However, the potential for either to seek a formal partnership with an entity that

lacks actual ties to or a stake in Southwest Virginia or East Tennessee is widely considered to be fraught with risk in terms of the provision of health care to residents throughout this region. This proposed local partnership between MSHA and Wellmont is much more likely to offer our citizens expanded yet affordable access to healthcare provided by high quality medical personnel.

I urge favorable consideration of the proposed merger, and I appreciate the opportunity to share these thoughts with you.

With best regards, I am

Sincerely,

Rebecca C. Coleman

CC: Attorney General Mark Herring

Office of the Attorney General

900 East Main Street

Richmond, VA 23219

1005 Glenway Avenue
Bristol, Virginia 24201-3473
(276) 466-3322

The United Company

November 11, 2015

The Honorable William Hazel, Jr., M.D.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, Virginia 23218

RE: Proposed Merger of Wellmont Health System and Mountain States Health Alliance

Dear Secretary Hazel:

The United Company, a diversified private investment company, is a long standing corporate citizen of the region with many of our employees working and living here. In addition to my duties at the Company, I serve as a member of the Board of Directors for Bristol Regional Medical Center and a member of the Population Health and Healthy Communities Steering Committee, a committee established jointly by Wellmont Health System and Mountain States Health Alliance to discuss the area's largest healthcare challenges and how best they can be addressed on a regional basis. We have several challenges and it will take outside-of-the-box solutions to help the region advance the quality of care needed.

A certificate of public advantage is deliberate in its attempt to provide the ability for uniquely positioned health care systems to come together under regulation and supervision from the state. It is my view that a certificate of public advantage provides an opportunity for this region to take an important step forward in ensuring quality, comprehensive and affordable health care. As you are aware, in accordance with the law, appropriate state officials will continue to act in an oversight capacity ensuring action taken is consistent with sound health care policy. Once approved and implemented, I would encourage you to help ensure steady cost monitoring and enforcement, but retain the ability for the proposed new health system to be nimble in meeting our population health needs.

I have heard, and understand in theory, concerns that have been raised by a few regarding reduced competition. As an employer who provides a self-funded insurance plan for our full-time employees, we appreciate efforts to keep quality healthcare affordable. However, as you know the proper evaluation to be made is not will there be less competition, but whether the benefits likely to result from a cooperative agreement outweigh the disadvantages likely to result from that reduced competition. It is here, looking at the benefits to be considered, including affordability, where I believe the scales tip clearly in favor of a carefully structured, and appropriately regulated, cooperative agreement.

One example cited, Mission Health System in Asheville, North Carolina, a community within a two hour drive of much of this region and with many similarities to it, appears to have operated effectively for years under a certificate of public advantage. It is my understanding that costs have risen at a lower rate than most of the nation and the system has been ranked by some near the very top of all health care providers across the country on clinical quality and efficiency. As health care policy continues to evolve in the years ahead, a strong system with the resources and experience needed to understand and tackle our unique needs will be critical.

Bottom line, given our unique needs the status quo is not getting us where we all collectively believe we need to go. However, through this proposed merger and within the proper regulatory environment we believe we can get there. Thank you for your important work on this initiative.

Sincerely,

Martin L. Kent
President and Chief Operating Officer

cc: The Honorable Mark Herring, Attorney General of Virginia

CUSTOMER 1 ONE, INC.
Bill Gatton

CHEVROLET Cadillac ISUZU

1000 West State Street • Bristol, Tennessee 37620 • (423) 764 5121 • www.billgatton.com

November 18, 2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dr. Hazel,

I am writing to you in regards to the proposed merger of Mountain States Health Alliance and Wellmont Health System

Our organization, Bill Gatton Automotive Group, employs 150 individuals in the Tri-Cities area of Tennessee and Southwest Virginia. Additionally we have physical operations in both states and have provided automotive services to this region for over 47 years.

We, as with most businesses, are very concerned with the cost and quality of available health care for our employees and customers. We live in a region where cardiovascular disease, obesity and drug abuse are major health challenges. Through this proposed merger and collaboration with East Tennessee State University along with Quillen College of Medicine and the Bill Gatton College of Pharmacy, we believe an informed and educated populace can change this tide.

Lower costs can be obtained by eliminating the duplication of services and technology these two health systems are employing today. We believe cost, through the COPA process, can be controlled by the supervision of the State of Tennessee and the Commonwealth of Virginia.

We fully support this proposed merger as a way to positively impact the way health care is delivered in our area and hope you will thoughtfully consider all of the benefits this merger will bring to our region.

Respectfully yours,

Chris Lee
COO Bill Gatton Automotive Group

cc: Attorney General Mark Herring, Office of the Attorney General, 900 East Main Street, Richmond, VA 23219

FRIENDSHIP ENTERPRISES

AUTOMOTIVE • INVESTMENTS • REAL ESTATE

July 24, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Commissioner John Dreyzehner,

Friendship has been in business since 1993. We are in the automotive / motorsports business with 16 locations throughout Bristol, Kingsport, Johnson City, TN as well as Boone and Forest City, North Carolina. We currently employ over 300 Team Members.

As you know, there has never been a time of greater change in health care – both locally in our region and across the U.S. Sweeping changes have been and will continue to occur for our nation's hospitals, physicians and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it.

Additionally, there are significant challenges facing our region:

o **Industry Challenges (for hospitals):** These include increasing reimbursement cuts, declining inpatient volumes, constrained revenue, and increasing difficulty in recruiting and retaining physicians.

o **Regional Health Issues:** Serious health issues in our region that need to be addressed include cardiovascular disease, diabetes, pulmonary disease, addiction and untreated mental illness – and the cost of this poor health is not sustainable. Additional factors unique to our region include the rural nature of many hospitals and the need to expand investment in research and physician training programs.

The proposed merger between Mountain States Health Alliance and Wellmont Health System is a response to these challenges, and an opportunity to change the way our local health care providers are able to work together to tackle the health care challenges affecting our region. This will be an opportunity for the two organizations to come together and build something brand new that reflects what this community really needs – today and in the years ahead.

As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose – to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access the best care available in the nation. By joining together, they could redirect spending away from wasteful duplication that has not added value, and invest in efforts to make our region healthier while controlling costs and making health care more affordable for all.

Together, Wellmont and Mountain States will:

o Work with East Tennessee State University to tackle important public health issues
o Enhance needed services, like substance abuse and mental health
o Expand access to care, while keeping healthcare affordable
o Better coordinate care through electronic health records
o Attract and retain the best and brightest physicians
o Strive to be one of the best healthcare employers in the nation

FRIENDSHIP ENTERPRISES

AUTOMOTIVE • INVESTMENTS • REAL ESTATE

In Tennessee, the two organizations are pursuing approval under the COPA (Certificate of Public Advantage) statute. Under a COPA agreement, our region's employers, patients and payors will be protected. State supervision will ensure the future combined organization will continue to benefit the community by providing health care that is affordable, accessible, cost-efficient and most importantly, high-quality.

I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

As someone who cares deeply about this region and our future, I hope you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

Sincerely,

Mitch Walters
President / CEO
Friendship Enterprises

NORTHEAST STATE

Office of the President

November 24, 2015

Commission John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Mr. Dreyzehner:

I am writing to provide how Northeast State Community College strongly supports the merger of Wellmont Health Care System and Mountain States Health Alliance. With six health related programs of study, it is critical that we have viable health care systems where our students can participate in clinical settings to enhance their skills as potential employees of these systems. It is also important to the citizens that we have a very strong, competitive system to meet the health care needs of our region. We believe that the two systems will be "Better Together."

Northeast State is celebrating 50 years in 2016 of service to the Northeast Tennessee Region. We added health programs over the last 10 years to meet the need of the health care providers and graduate around 150 students annually who live in this region and apply for health positions in the health care industry in this region. We enroll close to 400 students annually in AD Nursing, Dental Assisting, EMT, Cardio-Vascular, Medical Technology, and Surgical Technologies. We continually assess program needs to see if we need to add additional programs of study and also frequently ask our health system employers to identify skills sets that our graduates need to be the most successful if employed by our regional health care systems.

Northeast State has ranked first in TBR and UT Public 2 year and 4 year institutions in performance outcomes for the last two years in a row. We enroll around 7500 students annually and employ around 400 full time employees and approximately 250 part-time employees.

We have had close affiliation with both systems over the last several years and each has been a great partner, but the merger would provide event greater leverage and competitive edge for our region and as a college in providing a voice and impact for Northeast Tennessee in health care services. I have served on the workforce development board of directors for Mountain States Health Alliance and on the board for Indian Path Medical Center. Quality and integrity are two ways I would describe my experience with these great institutions.

Again, Northeast State Community College strongly supports the merger of Wellmont Health System and Mountains States Health Alliance to create one of the best systems in the nation.

Sincerely,

Janice H. Gilliam

Janice H. Gilliam, Ed. D.
President

Cc: General Herbert Slatery III

Northeast State
Community College
A Tennessee Board of Regents Institution

2425 Highway 75, P.O. Box 246
Blountville, TN 37617
423.323.3191 Fax 423.323.0209
www.NortheastState.edu

Town of Clintwood

Phone (276) 926-8383 • P.O. Box 456 • FAX (276) 926-9871
Email jsteele_townofclintwood@verizon.net
CLINTWOOD, VIRGINIA 24228

MAYOR
Donald Baker

COUNCIL MEMBERS
Danny Lambert
Talbert Bolling
Jeremy Fleming
Doris Rife
Ron Kendrick

August 3, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P.O. Box 1475
Richmond, Virginia 23218

Re: Proposed Merger between Wellmont Health System and Mountain States Health Alliance

Dear Dr. Hazel:

I am pleased to write to you in support of the proposed merger between Wellmont Health System and Mountain States Health Alliance. I believe the proposed partnership is an important step in improving and assuring excellent health care for the people of Southwest Virginia.

As you are well aware, there has never been a time of greater change and challenges locally in our region, across Virginia and in the United States for hospitals, physicians and patients. The ability for patients to get the healthcare they need and healthcare providers to deliver that care is critical but challenging.

With industry changes for hospitals in particular and the need for regional solutions regarding significant health care issues for the community, it is my opinion that all of our constituents can best be served by the proposed solutions proposed by the successful merger of these two well recognized healthcare leaders.

I am fully confident that the ongoing supervision provided by the Commonwealth of Virginia is more than sufficient to protect the region's employers, patients and payers. Additionally, it will ensure the future combined organization will continue to benefit the community by providing health care that is affordable, accessible, cost-efficient, and most importantly, high quality.

Thank you in advance for your careful consideration of this matter and if you have any questions at all, please feel free to contact me.

Sincerely,

Donald Baker
Mayor

cc: The Honorable Mark Herring
Attorney General of Virginia

Dickenson County Chamber of Commerce

"Shopping Locally Enhances our Community"

www.dickensonchamber.net

October 13, 2015

Dr. William Hazel Jr.
Secretary of Health & Human Services
P.O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel,

The Dickenson County Chamber of Commerce supports the merger of Wellmont Health System and Mountain States Health Alliance to an integrated single system.

We feel due to the overall challenges facing healthcare, this merger would be the best solution for our region in overall healthcare. We hope to see positive results from this merger in an overall better quality of life for our citizens in healthcare and for an enhanced economic growth in our counties.

Both Wellmont Health System and Mountain States Health Alliance have great assets and strengths. The merger between Mountain States Health Alliance and Wellmont Health System is an opportunity to change the way our local health care providers work together to tackle the healthcare challenges affecting our citizens in the region, thus making us a stronger community.

We see a positive future for our region and feel this comprehensive Health Care System will be an asset to retain and recruit businesses.

Our chamber cares deeply about our citizens and businesses in this region. We look forward to reaping the benefits this merger will bring to our region in the near future.

Sincerely,

Rita Surratt

Rita Surratt, President/CEO
Dickenson County Chamber of Commerce

P.O. Box 1990
Clintwood, VA 24228
194 Clintwood Main Street

276-926-6074(office)
276-275-1294(cell)

Mike McIntire
[redacted] Pendleton Place
Kingsport, TN 27664
November 2, 2015

General Herbert Slatery III
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, Tennessee 37202=0207

Dear General Herbert Slatery III:

Re: Support for Merger of Wellmont and Mountain State Health Systems

I am a long-term resident of Kingsport and current serve our city as Vice Mayor. My wife and I have had the need to utilize the services provided by both health systems and have always been pleased with the service and the outcome. I want to express my strong support for the merger of these two systems and to briefly state why I think this merger is in the best interests of the citizens in our region.

My support is based on the following:

- I recognize that the complex financial strains on the health care system are placing extreme pressure on all health care systems and controlling costs are essential to survival. Consolidations and mergers are the most obvious ways to achieve cost savings. Merger of our two local systems provides these cost savings while maintaining control of our hospitals in the region and their focus on the unique health needs. This has the highest probability of assuring high quality medical services that our communities need.
- While consolidation will likely result in some job reductions in some areas, the two systems together should be able to offer better medical services overall and should also be able to have sufficient patient load to add some subspecialty care which now requires patients to travel to larger systems.
- The combined system should be able to bring better focus on major health issues in our region including substance abuse, mental health, heart disease, diabetes, and obesity and help assure that our next generation is healthier than the current one.
- Concerns about monopolistic issues are largely unfounded because prices are controlled by the Federal government (Medicare and Medicaid) and insurance companies. I can see no reason that a merged health system could charge higher prices for medical services.
- Because of a significantly larger health care system, the opportunity to expand medical related work with East Tennessee State University to tackle public health issues in our region is an added bonus to the merger and one that has not only improved health implications but also economic development opportunities in the medical field in the region.

I believe these factors strongly favor your approval of the merger of Mountain State Health Alliance and Wellmont Health System and I strongly recommend your approval.

Sincerely,

Mike McIntire

S. H. Anderson, Jr.
161 Cherokee Street
KINGSPORT, TN 37660

TELEPHONES
Office — 423-247-6861
Fax — 423-247-6728
Lake — 423-538-6749
S.C. — 843-886-2929
Home — 423 [redacted]
Cell — 423 [redacted]

EMAIL [redacted]

HOME ADDRESS:
[redacted] Leedy Road
Kingsport, TN 37664

Kingsport, Tenn.

July 13, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Dear Mr. Dreyzehner:

Ford

I am very much for the merger of the Wellmont Health Care System with Mountain States Health Care System. This merger would give our two systems local control. With the East Tennessee State Medical School, we could greatly advance health care for the entire region. The merger would stop the duplication of so many services.

We operate three automobile dealerships here in Kingsport with over 100 employees. I have, along with my family, been involved with Wellmont since Holston Valley Hospital was built in Kingsport in 1932. My Father was a past President of the hospital and I was President of the Foundation and served on the hospital board for many years.

Chevrolet

Yours very truly,

S. H. Anderson Jr

Cadillac

S.H. Anderson, Jr.

CC: General Herbert Slatery III
Elliott Moore

Subaru

Volkswagen

LAW OFFICES
C. THOMAS DAVENPORT, JR.

P. O. BOX 966
BRISTOL, TENNESSEE 37621-0966

July 28, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

General Herbert Slatery, II
Office of the Attorney General and Reporter
P.O. Box 20207
Nashville, TN 37202-0207

Re: Proposed Merger between Wellmont Health System and Mountain States Health Alliance

Commissioner Dreyzehner, and General Slatery,

In my practice I serve as General Counsel to a number of locally headquartered businesses with employee counts ranging from 50 or 60 to 500. While my clients are in disparate fields, one major common denominator is that they are all struggling with the costs and complexity of providing health insurance for their employees in the current healthcare climate.

When the first statement of the intended merger was published I was initially dubious as to any benefit that would accrue to my clients from this action. However, at this point having read and listened critically to the case made for the merger by the respective representatives of these hospital groups, I am convinced that their intent is good, that their hearts are in the right place, and that this merger may be the last, best hope for maintaining the high quality of healthcare in our region.

They are serious about:

- marshalling resources and eliminating duplication;
- enhancing needed services like substance abuse, mental health and preventative care;
- expanding access; and
- maintaining high quality healthcare while keeping it affordable.

I support this proposed merger because I truly believe that together these organizations can impact in a major way the quality and affordability of healthcare delivered in our region.

As the process for approval of the Certificate of Public Advantage proceeds, I would urge you to consider the benefits this proposed merger would bring to our region and the bleak alternative for future generations if it can't go forward.

Thank you.

Yours very truly,

C. Thomas Davenport, Jr.

CTD/mjs

TELEPHONE: 423/ 989-6500 EMAIL: TOM@CTDLEGAL.COM FACSIMILE: 423/ 989-6509

Charles E. Good
[redacted]Town & Country Dr.
Jonesborough, TN 37659

July 27, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

RE: Proposed merger
MSHA and Wellmont

Dear Commissioner Dreyzehner,

I have recently retired as President and CEO of Frontier Health. Frontier Health, as you know, is a regional community behavioral health service. Services by 1000 staff are provided in the eight northeast counties of Tennessee and the three western most counties of Virginia.

I am writing to support the proposed merger between Mountain States Health Alliance and Wellmont Health System. I believe Frontier Health is an excellent example of "regional services" under the direction of a local board of directors. I believe MSHA and Wellmont can and will deliver and effective, efficient, and locally led health service throughout our region.

Both systems currently have excellent relationships with ETSU, our physician groups, Frontier Health, Mountain Home, and others throughout our communities. The systems proposed "local" solution is much preferable to other partnerships the systems have explored.

As I recall the COPA process was used by the local mental health agencies when Frontier Health was created in the late 1990s. Again, I believe the resulting benefit to our communities would mirror Frontier's success.

Affordable health care which is accessible and cost efficient is the predictable outcome if this merger is approved. The resulting benefit of regional high-quality health care is our goal.

Thank you for your consideration of this matter.

Respectfully,

Charlie Good

cc: General Herbert Slatery III
Office of the Attorney General and Reporter
PO Box 20207; Nashville, TN 37202-0207

Ideal Rental Properties

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Fax 423-391-0898 • E-mail: idealrent@aol.com

July 8, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Commissioner Dreyzehner,

I am a small business owner who has worked in this region all my life.

I have received care from both Mountain States Health Alliance and Wellmont Health, and I have the highest regard for their people and the services they provide. I endorse this merger because I believe healthcare is different than any other kind of business.

Competition has not resulted in lower prices and more services. Rather, it has caused an unnecessary duplication of services. I have a heart machine, you have a heart machine. I have a scanner, you have a scanner. Even though we're almost across the street from each other!

This merger gives us the opportunity to eliminate duplicate services and spend those precious resources on services we do not currently have in this region. I also believe that eliminating duplicate services will actually, in the long run, lower prices.

For these reasons, I urge you to approve the merger between the two organizations.

Sincerely,

Gary Gross

cc: General Herbert Slatery III

UBS

UBS Financial Services Inc.
214 E Mountcastle Drive
Suite 1-A
Johnson City, TN 37601
Tel. 423-928-7144
Fax 423-928-8738
Toll Free 800-729-4848

www.ubs.com

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

July 7th, 2015

Dear Commissioner Dreyzehner,

I am writing to you to voice my support for the impending merger of Mountain States Health Alliance and Wellmont Healthcare. I work in Johnson City for UBS Financial Services Inc. as a Vice President in their Wealth Management Division where between Johnson City and Kingsport we employ 10 advisors and 5 support staff and provide healthcare through Aetna to their families. Not only do we have a thriving business here in the Tri Cities but we also have made a huge investment in the state of Tennessee by moving a large part of our infrastructure system from New Jersey and New York to Nashville where our goal is to employ close to 1,000 people in the near future.

As an East Tennessee native having grown up in Johnson City in the 60's,70's and early 80's I was pleasantly surprised when I moved back in the late 90's from the likes of Cincinnati and Sacramento, California. Not only had Johnson City transformed from a retail perspective but we had also built a first class healthcare system to include a medical school, a top notch hospital system and first rate physicians.

With the rapid changes in healthcare and the costs and implications of ACA, I feel that it is imperative that the impending merger of MSHA and Wellmont be allowed to move forward. A strong healthcare system and educated employees are two of the main reasons people and businesses relocate and stay in areas. We are lucky to have both in the Tri Cities. We meet with clients all day long who are in support of the decision to merge both systems and keep those high paying jobs in our area free from outside pressures. A combined system will create synergies in patient care and research and thereby allow it to deliver even higher patient care at a reasonable cost.

So as a Financial Professional that is proud to live in East Tennessee, I would hope that you see the merits in the impending merger and the economic benefits to our community as well as the economic benefits to two of our largest employers. Thank you for your time and consideration of such an important decision for East Tennessee for many years to come.

Sincerely,

Brandon Linton
Vice President – Wealth Management

UBS Financial Services Inc. is a subsidiary of UBS AG.

July 8, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, Tennessee 37243

Commissioner Dreyzehner,

As a cancer survivor, I know how important it is to have access to quality healthcare and medical specialists close to home. I believe the merger of MSHA and Wellmont will provide us with new opportunities to recruit more specialists to Northeast Tennessee and Southwest Virginia.

Having lived here all my life, I have seen firsthand what happens to healthcare when two different systems try to compete. Particularly when it comes to specialists, I believe competition has actually made it harder to recruit and retain them in our region.

These specialists and subspecialists spend a lot of time and money to get trained. I understand they need a certain amount of patient volume for it to make economic sense for them to come to an area. Unfortunately, having two competing systems has meant we have been unable to get to the kind of volume these specialists need.

This merger will allow our physicians to work together to meet the needs of the people of our region. Please, I urge you, to approve this merger.

Sincerely,

Judy Seaton

Judy Seaton

cc: General Herbert Slatery III

STRONGWELL®

JOHN D. TICKLE
CHAIRMAN

July 28, 2015

Commissioner John Dreyzehner
Department of Health
425 5th Avenue North
Nashville, TN 37243

Dear Commissioner Dreyzehner:

I am writing you today to offer my support in inaugurating the Mountain States Health Alliance with the Wellmont Health System, both of which operate in Northeast Tennessee and Southwest Virginia.

Our company, Strongwell, provides health benefits to several hundred families which live in Northeast Tennessee and Southwest Virginia. Our health cost, besides raw material and labor cost, is our largest expense. Strongwell's health cost continues to be uncontrollable and rising each year in the double digit range.

Strongwell competes in a world economy and we ship our products all over the world. Strongwell is recognized as the world leader and the largest in our industry.

Over the years I have been very much involved with our health system, serving on the Bristol Regional Medical Board for 5 ½ years with 4 ½ of that as the Chairman. During that time, we built a brand new hospital at a new location which opened in 1994.

Obviously, for our region to continue to grow, prosper and provide opportunities for all its citizens, we must provide outstanding health care at an affordable cost. Change in the healthcare industry has been going on forever, but even more so at the present time and it appears that it will continue into the future. For the two health systems to survive and provide our communities with outstanding healthcare at the lowest cost possible, it is imperative that approval for the merger of the Mountain State Health Alliance and the Wellmont Health System be granted.

I appreciate your support. If you have any questions, please do not hesitate to give me a call at any time.

Sincerely,

John D. Tickle

cc: Attorney General Herbert Slatery III

Corporate Offices
400 Commonwealth Ave., P.O. Box 580
Bristol, VA 24203-0580 USA

Phone (276) 645-8000
FAX (276) 645-8132
jtickle@strongwell.com

FRIENDSHIP ENTERPRISES

AUTOMOTIVE • INVESTMENTS • REAL ESTATE

July 24, 2015

Elliott Moore
Vice President, Community and Government Relations
Mountain States Health Alliance
32 6th Street
Bristol, TN 37620

Dear Elliott Moore,

Friendship Enterprises was formed in 1993 and is primarily a group of retail automobile dealerships, motorsports franchises and an automotive service center. We have 16 locations throughout Bristol, Kingsport, Johnson City, TN as well as Boone and Forest City NC. We have over 300 team members employed at all of our locations.

It is no secret that the biggest concern in business is the cost and availability of health care. The sweeping changes that have occurred for our nation's hospitals, physicians and patients makes it almost impossible for patients, families and businesses to get the care they need, when and where they need it and at a cost that they can afford.

The vast majority of our team members cannot even afford health care premiums and it is a terrible burden for our companies as well. There must be a stop to the rising costs. It is possible for health care costs to actually drive companies out of business, and this is purely a devastating reality for our national economy.

I do not need to continue to review the facts that you already know, but I do believe that merging Wellmont and Mountain States into a single health care system would greatly benefit our entire region and its employers and citizens. As a matter of fact, this model should be utilized with every health care system in every market in America. We simply cannot afford the redundancies that we have now in our market.

We have competing facilities in nearly every market in our region and it is confusing for the patients and certainly not efficient in operating costs. Nearly every other business or entity has been forced to merge to survive and to provide the level of service required. This is necessary in both the private and public sectors.

The governing body of the State of Tennessee can and will insure that we have competitive pricing and a high level of service upon a merger between the two hospitals. This is the best opportunity we will ever have in our market to grow and create a super regional medical complex that could not only serve our area, but offer specialties that could benefit a global audience. This would be absolutely great for economic development in our region.

As someone who sincerely cares about our region, not only based on quality of life, growth and economic development, I hope you will consider all of the benefits of this proposed merger between

FRIENDSHIP ENTERPRISES
AUTOMOTIVE • INVESTMENTS • REAL ESTATE

Wellmont and Mountain States. It is the right thing to do not only today, but to benefit the next generation.

Please call me if you need further opinions or an explanation of this letter. There are so many reasons to support this merger.

Good Luck and God Bless.

With Best Regards,

Mitch Walters
President/CEO
Friendship Enterprises

1954 West State Street • Box 1967 • Bristol, TN 37621

Norton Redevelopment & Housing Authority
200 SIXTH STREET, N.W.
NORTON, VIRGINIA 24273-1989
TEL. 276/679-0020 • FAX 276/679-0026 • TDD 276/679-0020

July 24, 2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dear Sir:

The Norton Redevelopment and Housing Authority (NRHA) was Chartered by the City of Norton in 1958 to demolish blighted property and housing in the City and to help provide low income families with affordable, sanitary, and safe housing. The Authority employs 10+ employees and is subsidized by the U. S. Department of Housing and Urban Development.

Serving as the Executive Director of NRHA for the past 26 years I have seen health care cost in this area sky rocket. The Authority does offer all full time employees health insurance coverage but in some cases our employees and the 390+ residents we serve, have to drive 50+ miles to receive specialized medical care and procedures that is not offered locally.

As a business that helps those in need, I believe that integrating Wellmont and Mountain States into a single health system would greatly benefit my residents and employees. As a combined organization, Wellmont and Mountain States can combine their resources to make our region healthier while controlling costs and making health care more affordable. The union would also give them an advantage at drawing specialized talent and in obtaining specialized trauma services to the area.

On behalf of the NRHA I support this merger, because it will definitely impact the way health care is delivered in our region. Our region is a region to be proud of and I care deeply for it. I hope you will consider all the benefits this proposed merger will bring to our region in the years to come.

Sincerely,

John E. Black
Executive Director

Cc: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219

WASHINGTON COUNTY CHAMBER OF COMMERCE
1 GOVERNMENT CENTER PLACE, SUITE D
ABINGDON, VIRGINIA 24210

(276) 628-8141 FAX (276) 628-3984
WWW.WASHINGTONVACHAMBER.ORG
CHAMBER@BVU.NET

August 23, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P.O. Box 1475
Richmond, VA 23218

The Washington County, Virginia Chamber of Commerce endorses the proposed merger between Mountain States Health Alliance and Wellmont Health System. We stand with our colleagues from the Chambers of Commerce of Kingsport, Bristol and Johnson City/Jonesborough/Washington County Tennessee, who have also expressed their support for the proposed merger.

Our Chamber of Commerce represents well over 550 businesses and individuals. Our members represent industries as varied as banking, education, manufacturing, medical, professional services, and retail. Our members' experience ranges from multi-generation families to start-up businesses.

Our community's health needs span the spectrum of routine maintenance, advanced diagnostic and surgical procedures, cancer treatment and prevention, mental illness, and substance abuse. Our health needs also require accessible and affordable options.

We believe integrating Mountain States Health Alliance and Wellmont Health System into one locally governed health system would provide our community and region great benefits. Our residents already face the challenge of limited health insurance options and this proposed new, integrated system will allow our residents the opportunities to use the physicians and facilities closest to them. Further, we believe the proposed new health system will allow increased resources to be spent on patient care as opposed to non-patient centered resources demanded by competition.

We believe the active supervision of Virginia's Health Commissioner, individually or in collaboration with Tennessee, will ensure that excellent, accessible healthcare will be provided by the proposed new health system to our community at a reasonable cost. We are hopeful the elimination of duplicative advertising, recruiting, and regulation compliance efforts will provide enhanced patient offerings in order to make our communities healthier.

The proposed merger between Mountain States Health Alliance and Wellmont Health System will allow our communities to offer and provide qualified local leadership. Our current relationships with both systems give us comfort knowing local people will be making decisions locally.

Again, the Washington County, Virginia Chamber of Commerce endorses the proposed merger between Mountain States Health Alliance and Wellmont Health System. We believe this proposed merger provides the best opportunity to advance healthcare in our community and region.

Jamea Blevins
2015 President

CC: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219

July 15, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 24218

Dear Dr. Hazel:

I am Associate Director for the Southwest Virginia Higher Education Center, located in Abingdon, Virginia. The Center is 18 years old and serves as a campus for nine top-ranked colleges and universities within the Commonwealth. We provide opportunities for adults to obtain bachelor's, master's and doctoral degrees in over 96 fields of study. In addition, we offer a variety of professional development and non-degree programs for those who desire to improve their education while living at home and maintaining a full-time job. We have a staff of 45 individuals, both full- and part-time.

I support the proposed merger between Mountain States Health Alliance and Wellmont Health System because I believe that combining the two systems into a single system will truly impact the way healthcare is delivered in our region. We are geographically isolated from top-level healthcare systems, and economics and transportation often prevent local residents from traveling great distances to obtain state-of-the-art healthcare. The merger of these entities will eliminate a duplication of services that has neither added value nor improved healthcare for our region. The cost savings could be invested in efforts to make our region healthier while controlling costs and making healthcare more accessible to our residents.

A combined organization, coupled with the nation's top leadership in healthcare administration, could benefit our community by providing healthcare that is affordable, accessible, cost-efficient and most importantly, high-quality.

I hope you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

Sincerely,

William D. Carmack
Associate Director

One Partnership Circle

PO Box 1987

Abingdon, VA 24212

(276) 619-4300

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Colgard Outdoor Sports

July 23, 2014

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P. O. Box 1475
Richmond, VA 23218

Dear Secretary Hazel:

As an owner of a small business operating in Wise County, Virginia, I am pleased to offer a letter of support for the proposed merger between Wellmont Health System and Mountain States Health Alliance. The availability of comprehensive, affordable and accessible health care is a crucial factor in the economic health of our community and subsequently directly impacts the success of my business.

My brother and I are owners of Colgard Outdoor Sports located in Norton, Virginia. It is a small family-owned business, which we have transitioned from a mining supply sales operation established in 1978 to a sporting goods retail business as the mining business receded in our area. We employ a total of 9 individuals.

As a small employer, it has always been a struggle to provide health insurance benefits to our employees. The implementation of the Affordable Care Act did not ease that struggle; it merely changed the dynamics we have to deal with to provide health benefits. Both our employees that have health insurance benefits and those that do not need access to health services and sometimes those are simply not readily available.

I would describe the Wise County health care environment as consisting of "too much but too little" from a services perspective. With three hospitals in our county, there is emergency room access and acute care access, and should be described as excessive access. What we desperately have too little of would be mental health and substance abuse care, and preventive and specialty care. In the customers I serve on a daily basis, I see too often the effects of lack of education about health issues. We have significant heart disease and pulmonary issues that are often the result of the high incidence of smoking in our region. We are living in a reactive health care environment rather than one that is proactively working towards improving the health of the residents of the area.

600 Park Avenue NE, P. O. Box 757, Norton, VA 24273
276-679-1728

I believe the joining of the two health systems would combine resources and make available levels of care that do not exist today. With the supervision of the state governments in Virginia and Tennessee, the fear that many have about lack of competition increasing cost can be overcome. Perhaps the focus that needs to be shifted to the needs for specific areas of care could occur if the systems become one system working to improve health overall.

I do believe a new health system would be a positive for the region. My business is a small business but I believe where healthcare is concerned "Bigger Is Better". The combined resources of these two quality systems could change the way health care is provided in our region and improve the health of our residents.

Thank you for the opportunity to share my thoughts on the proposed merger.

Sincerely,

Roderick A Colyer

Roderick A. Colyer
Colgard Outdoor Sports

cc: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219

Virginia Highlands Community College
P.O. Box 828 • Abingdon, Virginia • 24212-0828
www.vhcc.edu • 276-739-2400

July 28, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P.O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel,

It is my pleasure to submit this letter in support of the proposed merger between Wellmont Health System and Mountain States Health Alliance.

As you know, Virginia's community colleges were created nearly a half century ago to address the unmet needs in the communities they serve. Virginia Highlands Community College takes that mission seriously and has established itself as a leading provider of quality, affordable higher education in Southwest Virginia. Working closely with business leaders and community organizations throughout the City of Bristol, Washington County and Smyth County, VHCC has made significant contributions to the economy and overall quality of life that we enjoy in our region.

A key to VHCC's success has always been its strong working relationship with the area's healthcare providers. In fact, the Virginia Appalachian Tricollege Nursing Program - a joint venture of VHCC, Mountain Empire Community College and Southwest Virginia Community College – is a leading provider of registered nurses in our region. Graduates of VHCC's Radiology, Paramedic, and Nurse Aide programs are also working throughout our region, providing quality care that makes Southwest Virginia a great place to live. VHCC remains committed to each of these programs and to maintaining cooperative partnerships with both Wellmont and Mountain States.

Just as VHCC has evaluated and adjusted its programs throughout the years to meet the changing needs of our community, the time may have come for our region's healthcare providers to evaluate the way our healthcare is delivered to our area. The idea behind the merger is to create a stronger healthcare system that is better equipped to meet the medical needs of our community.

Thank you for allowing me to share my thoughts on this important issue.

Sincerely,

Dr. Gene C. Couch, Jr.
President

cc: Attorney General Mark Herring

Fax: 276-739-2590 • Toll Free (in selected areas): 1-877-207-6115 • All above lines are Voice/TDD

E. DILLON & COMPANY™

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P.O. BOX 160 Swords Creek, Virginia 24649 (276) 873-6816
Fax (276) 873-4208

August 11, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P O Box 1475
Richmond, VA 23218

Dear Dr. Hazel:

E. Dillon & Company has been an employer in Russell County Virginia since 1962. We presently have 87 employees most of whom live in Russell and surrounding counties. The rural areas are very difficult to attract doctors and other health care providers.

I believe that underutilization of facilities and duplication of services has increased costs significantly. I support this proposed merger between Mountain States and Wellmont, and I think it would help contain health care cost for our employees and our company and provide more services than presently offered.

I believe that the state's active supervision will ensure the health and economic well-being of the region.

Quality health care and cost containment are vital for all employers in the region as a benefit to their employees. Rising health care costs for our company have exceeded annually the CPI which has made it more difficult each year to provide quality health coverage for our employees. I believe the merger will help control this cost in the future.

I support and endorse the merger of Mountain States Health Alliance and Wellmont Health System.

Sincerely,

Otey C. Dudley
President Emeritus

CC: Attorney General Mark Herring

South-West Insurance Agency, Inc.

BIG STONE GAP OFFICE
220 Wood Avenue East | P.O. Drawer S
Big Stone Gap, Virginia 24219
(276) 523-4111
(276) 523-5208 Fax

NORTON OFFICE
132 11th Street, SW | P.O. Box 700
Norton, Virginia 24273
(276) 679-3511 | (800) 679-2551 | (276) 679-3537 Fax
Financial Services: (800) 523-3770

JONESVILLE OFFICE
241 Hill Street | P.O. Box 346
Jonesville, Virginia 24263
(276) 346-1932
(276) 346-1813 Fax

July 20 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
PO Box 1475
Richmond VA 23218

Dear Dr. Hazel,

South-West Insurance Agency, Inc., has offices in Norton, Big Stone Gap, Jonesville VA, and Johnson City TN and employs thirty individuals in Virginia and Tennessee. We sell property, casualty, life and health insurance to customers in both states. Our business was established in 1908.

We believe that the merger of Mountain States Health Alliance and Wellmont would improve the delivery of health insurance in both states. The combining of these two entities would help attract the best and brightest physicians. The merger would better coordinate care through electronic health records. It would also enhance needed services such as mental health care and substance abuse treatment.

In closing, the proposed merger is an opportunity to change the way health care is delivered in both Virginia and Tennessee.

Sincerely,

Kenny Gilley

James K. Gilley
Senior Vice President
South-West Insurance Agency, Inc.

First Bank
& Trust Company
Member FDIC
P.O. Box 1000 • Abingdon, VA 24212 • 276-623-2323 • Fax: 276-628-5860

August 7, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel,

The purpose of my letter is to express my support for the proposed merger between Wellmont Health System and Mountain States Health Alliance. As the CEO of the 12th largest Virginia banking institution, headquartered in southwest Virginia, I am keenly aware of how both health organizations have impacted our employees and our business operation. Under the current scenario, both health organizations are in strong competition with each other to utilize their health service, often to the detriment of the patient. For example;

1) Both Wellmont and Mountain States have specialized health services unique to their own organization. Yet under the current scenario, a very limited amount of patient information is shared, thereby necessitating duplication of testing when most specialized services are time sensitive.
2) Statistical data clearly indicates that serious health issues unique to the rural nature of our region clearly exist and need to be addressed. By combining both health originations and eliminating the duplication of administrative costs, attention and resources can be redirected to addressing cardiovascular disease, diabetes, addiction and untreated mental illness, so prevalent in southwest Virginia and east Tennessee.
3) Increased difficulty in recruiting and retaining qualified physicians to our region has negatively impacted the quality of health care for our employees. By combining both organizations, I believe we have a much stronger and boarder health provider capable of recruiting and retaining the best and brightest physicians for the benefit of our community.

I further support this proposed merger because I believe that both organizations working together as one, can positively impact the quality and delivery of health care to southwest Virginia and east Tennessee. A local solution to our region's health care challenges is a much better scenario than partnering with a health entity located outside of our area, that are more concerned about pricing and increasing inpatient volume than about the ultimate heath care of the people in our region.

As someone who cares deeply about our region and our future, I hope you will favorably consider the benefits that this merger will bring to the region.

With kindest regards,

William H. Hayter
President & CEO

WHH/al

CC: Attorney General, Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219

FARM CREDIT
Country Mortgages

7/27/2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dear. Dr. Hazel,

I am writing on behalf of Farm Credit of the Virginias to express our support of a strong local medical care system that is affordable, accessible and cost efficient.

Farm Credit of the Virginias is a part of the Farm Credit System which was established in 1916 and is the largest single provider of agricultural credit in the United States. With more than 20 branches across our footprint, our employees are hometown people who are involved in their communities. Because of this, we know it is increasingly important for those in rural areas to have access to top quality, affordable health care and a local medical system that can tailor health care to address specific regional health issues.

The proposed merger between Wellmont Health System and Mountain States Health Alliance has the potential to have a positive impact on health care in this region by providing this important local medical care system.

Sincerely,

David E. Lawrence
Chief Executive Officer
Farm Credit of the Virginias

Cc: Attorney General Mark Herring

LEONARD COMPANIES, Ltd.

LEONARD
LAND &
LIVESTOCK

DAVID A. LEONARD
President

1780 East Main Street, Box 10
276-889-4252
276-889-5655 Fax
leonardcompanies@bvunet.net
www.leonardcompanies.net

July 20, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Services
P. O. Box 1475
Richmond, VA 23218

Dr. Hazel:

We are writing this letter in support of the proposed Mountain States Health Alliance/Wellmont Health System corporate coalescence.

Leonard Companies has been doing business in Southwest Virginia for 61 years and we are primarily involved in commercial development and leasing of land, in agriculture, and investment activities. We have seen many changes to our community of southwestern Virginia and northeast Tennessee through these years, and believe today's biggest challenges facing the Russell County community are medical mental health, addiction to both illegal and prescription drugs, and obesity.

We believe that the merger of these two health systems will assist the five-state region by enhancing quality physician recruitment, provide a broader array of medical specialists available to the rural communities of our area, assist in the economic development of our area, and focus more of the two health systems' funds on medical care, alleviating competition and duplicated costs related to two separate entities.

As business people and citizens of the area that will be affected, we are in support of the merger because we believe that a united Mountain States and Wellmont will promote creativity, accelerate insight and technology, resulting in a positive impact on the way health care is delivered in our region.

Sincerely,

David A. Leonard
President

David A. Leonard II
Vice-President

Sarah Leonard Wilson
Vice-President

cc: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219

07/21/2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Mr. Hazel:

My name is Michael McCool and I am a Vice President and Partner at Cary Street Partners in Abingdon, VA. Cary Street Partners is a Wealth Management and Investment Banking firm based in Richmond, VA. Our practice in based in Abingdon, VA. I am writing this letter in support of the merger between Wellmont Health System and Mountain States Health Alliance.

As you know, there has never been a time of greater change in health care, both locally in our region and across the United States. Sweeping changes have been and will continue to occur for our nation's hospitals, physicians, and patients, in many cases making it harder for patients, families and businesses to get the care they need, when and where they need it. In our region specifically, it is of great importance that we have a thriving, economically viable hospital system. Not only do our citizens need and deserve the best care, but also with the downturn in the energy markets, we need the jobs. In our rural area we need to expand investments into the quality and availability of care in all areas. I feel this merger will help achieve that aim. I feel the proposed merger is a response to the challenges that face our area.

As a combined organization, Wellmont and Mountain States believe they can work to unite the resources of both systems with one common purpose, to make the next generation of this region healthier than today's, and to make sure those who need health care services today can access health care that can compete with any other area in the nation. I feel that by coming together these two units can reduce wasteful expense and invest in efforts to make sure our region has access to the best doctors and care, all while making it more affordable to the patient. In closing I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. As a citizen who cares deeply about the present and future of our region, I hope you will consider all of the benefits this proposed merger will bring to our region not only immediately, but for generations to come. Thank you.

Sincerely,

Michael F. McCool
VP/Partner
Cary Street Partners, LLC

DAMASCUS
Corporation
P.O. Box 610
Abingdon, VA 24212
(276) 676-2376

7/23/15

Dr. William Hazel Jr.
Secretary of Health and Human Services
P.O. Box 1475
Richmond, VA 23218

Dear Secretary Hazel:

I am writing this letter as a small business owner living and working in Southwest, Virginia. My partners and I own 2 manufacturing operations in Abingdon, VA and a 3rd operation in Bluefield, VA. Our 60+ employee base comes primarily from Southwest, VA but as far away as Southern, WV and East, Tn. I am also writing this letter as a community board member of Johnston Memorial Hospital located in Abingdon, VA.

In the last decade we have seen tremendous change in the health care benefits we offer our employees. Much, but not all of the change has been positive. In our rural part of Virginia establishing top-notch, cost effective healthcare is often challenging on a personal level. On a corporate level we have had only provided one health network for employees for many years. My business partners and I are encouraged by the potential integration of Wellmont and Mountain States. For many years we have been concerned about the future ability of our rural health providers to remain financially relevant in today's rapidly changing healthcare environment. We believe the combined entity will allow for better recruitment of doctors and professionals to the region, stronger financial position that will allow utilization of the latest healthcare technology and equipment, and better access for our employee base.

As our Secretary of Health I am sure you are aware of the poor health statistics our region maintains. We believe a combined health system that maintains local headquarters in our region is the only way to keep a high level of care and address the challenges of our rural population. In the past years we have seen many industries leave our area draining the base of talented, well-educated individuals. We urge you and your agency to support the merger of Wellmont and Mountain States to keep our health system focused on the needs of our region and financially capable of continuing to meet the ever changing healthcare environment.

Sincerely

Eric Miller, CPA
President
Damascus Corporation
Platnick Crane and Steel
Wolf Hill Fabricators

Cc: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, VA 23219

STRONGWELL®

JOHN D. TICKLE
CHAIRMAN

July 29, 2015

Dr. William Hazel Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dear Dr. Hazel:

I am writing you today to offer my support in inaugurating the Mountain States Health Alliance with the Wellmont Health System, both of which operate in Northeast Tennessee and Southwest Virginia.

Our company, Strongwell, provides health benefits to several hundred families which live in Northeast Tennessee and Southwest Virginia. Our health cost, besides raw material and labor cost, is our largest expense. Strongwell's health cost continues to be uncontrollable and rising each year in the double digit range.

Strongwell competes in a world economy and we ship our products all over the world. Strongwell is recognized as the world leader and the largest in our industry.

Over the years I have been very much involved with our health system, serving on the Bristol Regional Medical Board for 5 ½ years with 4 ½ of that as the Chairman. During that time, we built a brand new hospital at a new location which opened in 1994.

Obviously, for our region to continue to grow, prosper and provide opportunities for all its citizens, we must provide outstanding health care at an affordable cost. Change in the healthcare industry has been going on forever, but even more so at the present time and it appears that it will continue into the future. For the two health systems to survive and provide our communities with outstanding healthcare at the lowest cost possible, it is imperative that approval for the merger of the Mountain State Health Alliance and the Wellmont Health System be granted.

I appreciate your support. If you have any questions, please do not hesitate to give me a call at any time.

Sincerely,

John D. Tickle

cc: Attorney General Mark Herring

Corporate Offices
400 Commonwealth Ave., P.O. Box 580
Bristol, VA 24203-0580 USA

Phone (276) 645-8000
FAX (276) 645-8132
jtickle@strongwell.com

Miners Exchange Bank
P.O. Box 1197
Coeburn, Va. 24230 ***276-395-2230***

July 21, 2015

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, Va. 23218

CC: Attorney General Mark Herring
Office of the Attorney General
900 East Main Street
Richmond, Va. 23219

Dear Gentlemen;

I am the President and Chief Executive Officer of Miners Exchange Bank. Our bank was chartered in 1982 and has been blessed to serve the citizens of Southwest Virginia and Northeast Tennessee for the past 33 years. Our corporate office is located in Coeburn, Va. and we have four other branches located in Wise County. We also have been operating in Northeast Tennessee for the past decade with a branch located in Gray, Tennessee. We are a full-service commercial bank that offers a full array of financial services to our clientele'. We currently employ approximately 70 individuals at our main office and branch locations.

I have closely watched the development of the healthcare industry in our region over the past thirty years. Wise County is considered to be a rural area, and our access to many of the specialty services offered by the larger hospitals has been somewhat limited. Competition between the larger hospitals to provide primary care to the people of this area has, in my opinion, somewhat thwarted the ability to attract the level of specialty services that are needed in this area. I am very excited about the potential merger between Wellmont and Mountain States into a single health system. We presently have three hospitals in Wise County which, in my opinion, is two too many. A single strong hospital in Wise County with access to expanded services would be a great asset to our people. I sincerely believe that a united effort would bring an increase of service lines and a greater focus on the healthcare needs of the people of our region.

Miners exchange Bank is one of the larger employees in Wise County, Virginia. Many of our employees must travel to the larger tertiary care hospitals in the Tri-Cities area whenever a more complex procedure is necessary. This creates hardships for families that have to make the travel to these hospitals. I realize that sometimes it is necessary to be transferred to a larger facility that possesses the level of expertise that is necessary to treat certain illnesses. However, with a unified focus on the health needs of our communities, I believe that the proper level of services could be provided that would ensure that the quality and accessibility of proper healthcare to the citizens of Northeast Tennessee and Southwest Virginia. I feel confident that, with the supervision and guidance

that would be provided by the state, the merger of these two hospitals would be a great blessing to our region.

In this time of sweeping change in the healthcare industry, a merger of these two hospitals would be beneficial in many ways. I believe that we would have:

- Expanded services
- The ability to attract an even greater pool of top physicians
- A greater pool of resources
- Less competition and more cooperation
- Greater focus on the particular healthcare needs of each locality in the service area
- More affordable healthcare

I whole-heartedly support this merger and feel that it is the best opportunity that we have ever had, or likely ever will have, to positively affect the way that healthcare is delivered in our region. I encourage you to be supportive of this effort as well.

If you have any questions, or would like to contact me directly, please feel free to do so. I may be reached at the number above, at my direct dial number (276-395-2711) or at my cell number (276-219-2101).

Sincerely,

Charles R. Ward
President

Dr. Weberling & Associates

Dr. William Hazel, Jr.
Secretary of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

1701 Euclid Avenue
Bristol, VA 24201
Phone: 276-466-4227
Fax 276-466-3937

Wise County Shopping Plaza
Wise, VA 24293
Phone 276-679-5612
Fax 276-679-0978

Dear Dr. Hazel,

I have been a practicing Virginia optometrist, with offices in Bristol and Wise, Virginia, for the past thirty years. What I have witnessed over those years, especially in Wise, is a dire need for assessable health care. The union of Wellmont and Mountain State Hospitals would enable a synergy that the two hospitals by themselves do not provide.

Since arriving in Bristol in 1974, I have been involved, and served, on numerous non-profit boards, as well as many city committees. As Mayor of Bristol, Virginia, I became even more aware of the needs of our community and our citizens. The benefits of this merger to Bristol are clear; the reduction of expenses in health care is very necessary in this high unemployment and low salary area. These two institutions will be able to provide unified care, and funds used for duplication of services will be eliminated. Using the best of both systems, our citizens will get the best care at a reduced cost. The active supervision of both states will ensure our citizens the finest health care at an affordable price.

Northeast Tennessee and southwest Virginia are the most overlooked areas in both states. This union is needed to help attract jobs to our region.

Thank you for your time, and I hope you concur that this will be a benefit for our citizens.

Douglas R. Weberling, O.D.
Randy A. Birt, O.D.

Douglas R. Weberling, O.D.

JASA GENERAL CONTRACTOR
J.A. STREET & ASSOCIATES

CC General Herbert Slatery III

245 Birch Street
P.O. Box 725
Blountville, TN 37617
Phone (423) 323-8017
Fax (423) 323-1065

July 29, 2015

Commissioner John Dreyzehner

Depart of Health

425 5th Avenue

Nashville, Tennessee 37243

Dear Commissioner Dreyzehner,

As a resident of the Bristol, Tennessee community I support and encourage in the investigation for the merger of the Wellmont and Mountain States Hospital. I believe we can find a better, more cost effect, and better health care by combining the best of both organizations.

As a business owner of JA Street and Associates for 30 years in the Bristol Community, I've also experienced the continuing health cost increase with less coverage to my employees and me. I'm hoping by combining services with the proposed merger, local heath insurance cost will lower while care increases.

In Tennessee, the two organizations are pursuing approval under the COPA (Certificate of Public Advantage) statute. Under a COPA agreement, our region's employers, patients and payers will be protected. State supervision will ensure the future combined organization will continue to benefit the community by providing health care that is affordable, accessible, and cost-efficient and most importantly, high-quality.

I support this proposed merger because I believe that together, Wellmont and Mountain States will be able to truly impact the way health care is delivered in our region. This local solution to our region's health care challenges is a far better scenario than other partnerships Mountain States and Wellmont have considered outside our community – partnerships that have been shown elsewhere to lead to increased pricing without necessarily improving quality.

As someone who cares deeply about this region and our future, I hope you will thoughtfully consider all of the benefits this proposed merger will bring to our region, both today and in the generations to come.

Thank you,

JA Street

Jim Street
Founder and CEO
JA Street and Associates

CC General Herbert Slatery III

Commissioner John Dreyzehner

Department of Health

425 5th Avenue North

Nashville, Tennessee 37243

Dear Commissioner Dreyzehner,

I am writing in support of the proposed merger between Mountain States Health Alliance (MSHA) and Wellmont Health System (Wellmont).

I recently retired as Vice President and General Manager for CenturyLink in Tennessee and Western North Carolina having worked in the industry for more than 32 years. As a major regional employer in the highly competitive communications industry, CenturyLink was challenged to provide a competitive health benefit plan for employees while keeping costs down as much as possible. With a significant number of our employees in a bargained for environment, the cost of health care was always a difficult discussion at the negotiating table. Clearly no one likes benefits to be reduced or costs to be increased. And in the bargained for environment, companies are locked in for several years to whatever they negotiate. I firmly believe merging MSHA and Wellmont will aid CenturyLink and others with common challenges. Having spent many years seeing how services might be duplicated between the systems or requests for donations to purchase much needed equipment were sought from both, I can tell you there has been great interest in how to control costs for years.

I am an elected member of the Johnson City Board of Education and I see directly the impact of our region's health issues on our students, employees and families. With the COPA expectations, I am confident with the focus of a combined organization we can begin to see a reduction in the incidence and severity of issues such as diabetes, addiction and cardiovascular disease. By having a laser focus on these health issues and collaborating with ETSU, true improvements can be realized.

I also serve on the board of Frontier Health and realize how much better we can serve our region's mental health needs with the combined system and partnership with Frontier. The ability to have access to services more readily available with the combined footprint of MSHA and Wellmont will be a wonderful outcome of the merger.

I also have been chair of our local chamber and our economic development organization. Having quality health care and controlling costs are huge goals for economic development and retaining and growing our existing businesses. And I am very excited by the opportunity to see money that has previously

been used for duplicated services be used in a more strategic way. Those monies can be used to either invest in research and solutions to our region's health issues or to purchase state of the art equipment one time versus for two systems.

Thank you in advance for your strong consideration and yes vote to approve the proposed merger. I truly feel our region will benefit by the combined organization.

Regards,

Lottie Fields Ryans

Exhibit 11.1

Signed Copy of the Cooperative Agreement

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

EXECUTION COPY

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EXECUTION COPY

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

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

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

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

Article I Shared Vision and Guiding Principles.

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

Section 1.02 Community Benefit.

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

(b) Parent Company will operate in accordance with the "community benefit standards" as they apply to Code Section 501(c)(3) hospital non-profit corporations, including, without limitation, the (i) acceptance of all Medicare and Medicaid patients, (ii) acceptance of all emergency patients without regard to ability to pay, (iii) maintenance of an open medical staff (subject to certain exclusive physician service arrangements in connection with the provision of hospital-based specialty medical services approved by the governing body of Parent Company from time to time), (iv) provision of public health programs of educational benefit to the community, and (v) general promotion of public health, wellness, and welfare to the community through the provision of health care at a reasonable cost.

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

(d) Parent Company will abide by policies and provisions of charity care that are no less generous than the policies of the Parties in effect as of the Effective Time, subject to changes in law, policy or regulation as applicable. Notwithstanding Parent

Company's commitment to maintain and abide by charity care policies as generous as past policies, nothing herein guaranties any particular level of furnished charity care.

Article II System Structure.

Section 2.01 Actions and Amendments to Organize Parent Company.

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

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

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

(d) Board of Directors of Parent Company.

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

(ii) The directors of Parent Company shall be selected on the following principles. Wellmont and MSHA will each appoint six (6) members to serve on the Board of Directors of Parent Company. Wellmont and MSHA will jointly select two (2) members of the Board of Directors of Parent Company, who shall not be incumbent members of the board of directors of either Wellmont or

MSHA. At least two of the persons appointed by each of Wellmont and MSHA shall be licensed physicians who are members of the medical staff of one or more hospitals affiliated with Parent Company; provided, however, that at no time will the number of Interested Persons on the Board of Directors who have voting rights be more than a minority of the total number of directors who have voting rights, and provided further that the total number of voting Directors shall not exceed 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

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

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

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

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

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

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

Section 2.06 Indemnification, Exculpation and Insurance.

(a) The Amended Parent Company Bylaws, Amended MSHA Bylaws and Amended Wellmont Bylaws shall include the fullest indemnification and exculpation of the current and former directors, officers, and board committee members of each organization or who served at the request of any of them as a director or officer of another Person (the “Indemnified Parties”) that is allowable under Tennessee law both with respect to service prior to the Effective Time and with respect to service following the Effective Time. Such Bylaws shall also provide for advancement of the costs of defense upon a finding by the Parent Company Board of Directors that the individual seeking advancement of such costs met the standard of conduct for indemnification and upon the individual providing a written undertaking to repay the advanced amounts in the

event that the Parent Company Board of Directors ultimately determines that the individual was not entitled to indemnification under applicable Tennessee law.

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

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

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

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

Article III Representations and Warranties of Wellmont.

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

Section 3.01 Effect of Agreement. Assuming the due execution and delivery of this Agreement by MSHA, this Agreement is a legal, valid, and binding obligation of Wellmont and is enforceable against it in accordance with its terms, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other laws affecting creditors' rights generally and except as enforceability may be subject to general principles of equity. Except as set forth in a confidential memorandum delivered by Wellmont legal counsel to MSHA legal counsel prior to the date of this Agreement (the "Wellmont Counsel Memorandum"), the execution, delivery and performance of this Agreement by Wellmont are within its corporate powers. Except as set forth in the Wellmont Counsel Memorandum, or otherwise expressly provided in this Agreement, the execution, delivery, and performance of this Agreement by Wellmont and the consummation of the transactions contemplated hereby by Wellmont will not: (i) require the consent, approval, or authorization of any person, corporation, partnership, joint venture, or other business association or public authority; (ii) violate any provisions of law applicable to Wellmont or to any of the Wellmont Subsidiaries now or immediately prior to the Effective Date; (iii) with or without the giving of notice or the passage of time, or both, conflict with or result in a breach or termination of any provision of, or constitute a material default under, or result in the creation of any lien, charge, or encumbrance upon any of the properties or assets of Wellmont or any of the Wellmont Subsidiaries pursuant to, any corporate charter, bylaw, indenture, note, bond, pledge, mortgage, deed of trust, lease, license, contract, agreement, commitment, or other instrument or obligation, or any order, judgment, award, decree, statute, ordinance, or regulation, to which Wellmont or any of the Wellmont Subsidiaries is a party or by which Wellmont or any of the Wellmont Subsidiaries or any of their respective material assets or properties may be bound; or (iv) result in the acceleration of any indebtedness of Wellmont or any of the Wellmont Subsidiaries or increase the rate of interest payable by Wellmont or by any of the Wellmont Subsidiaries with respect to any indebtedness.

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

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

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

(b) Each Wellmont Subsidiary has the corporate power, or power under the Tennessee Limited Liability Company Act, 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.

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

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

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

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

Section 3.06 Absence of Certain Changes. Except as set forth in the Wellmont Counsel Memorandum, as disclosed to MSHA prior to the date hereof through the process established in Section 5.04 for sharing Competitive Sensitive Information (the “Black Box Process”), or as

permitted by this Agreement, since the Balance Sheet Date, Wellmont has suffered no Material Adverse Effect.

Section 3.07 Contracts. The Wellmont Counsel Memorandum contains a list of all contracts, agreements, commitments, and arrangements to which Wellmont or any of the Wellmont Subsidiaries are a party or by which any of their assets are bound or affected that: (i) involve the expenditure by Wellmont or any of the Wellmont Subsidiaries thereto of more than $250,000 on an annual basis; or (ii) to the Knowledge of Wellmont, are with, or relate to, any physician; or (iii) to the Knowledge of Wellmont, are with, or relate to, any Disqualified Person within the meaning of Section 4958(f) of the Internal Revenue Code of 1986, as amended (the "Code")(each a "Wellmont Material Contract"). "Knowledge of Wellmont" when used in this Agreement means the actual knowledge of the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or the General Counsel of Wellmont. For avoidance of doubt, the term Disqualified Person shall include persons (including any physicians or their family members) who are or were, at any time during the five-year period ending on the Effective Date: (a) voting members of the subject organization's governing body; (b) presidents, chief executive officers, chief operating officers, and other persons with ultimate responsibility for implementing the decisions of the governing body or for supervising the management, administration, or operation of the organization, regardless of title; (c) treasurers and chief financial officers and other persons with ultimate responsibility for managing the finances of the organization, regardless of title; (d) in a position to exercise substantial influence over the subject organization's affairs, including (i) persons who have or share authority to control or determine a substantial portion of the organization's capital expenditures, operating budget, or compensation for employees, (ii) persons who manage a discrete segment or activity of the organization that represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole, (iii) persons who are substantial contributors to the organization (within the meaning of Code Section 507(d)(2)(A)), taking into account only contributions received by the organization during its current taxable year and the four preceding taxable years; and (iv) persons whose compensation is primarily based on revenues derived from activities of the organization, or of a particular department or function of the organization, that the person controls; (e) family members of persons meeting a definition in (a)-(d) above (for this purpose, "family members" are limited to the following: spouse, brothers or sisters (by whole or half-blood), spouses of brothers or sisters (by whole or half-blood), ancestors, children, grandchildren, great grandchildren, and spouses of children, grandchildren, and great grandchildren); and (f)(i) a corporation in which persons described in (a)-(e) own more than 35 percent of the combined voting power; (ii) a partnership in which persons described in (a)-(e) own more than 35 percent of the profits interests; or (iii) a trust or estate in which persons described in (a)-(e) own more than 35 percent of the beneficial interests. Other than as set forth in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries has entered into any Wellmont Material Contract. All Wellmont Material Contracts are valid and enforceable in accordance with their terms, except as such enforceability may be limited by bankruptcy, insolvency, receivership, and other laws affecting creditors' rights generally and general principles of equity. Wellmont and the Wellmont Subsidiaries and, to the Knowledge of Wellmont, all other parties to each of the foregoing arrangements, have performed in all material respects their respective obligations to date required to be performed under each Wellmont Material Contract. Except as disclosed in the Wellmont Counsel Memorandum, neither

Wellmont nor any of the Wellmont Subsidiaries nor, to the Knowledge of Wellmont, any other party, is in default or in arrears in any material respect under the terms of any of the foregoing arrangements, and no condition exists or event has occurred that, with the giving of notice or the lapse of time or both, would constitute a material default under any of them. Except as noted to the contrary in the Wellmont Counsel Memorandum, none of the rights of Wellmont or any of the Wellmont Subsidiaries under any of such agreements is subject to termination or modification as the result of the transactions contemplated by this Agreement. Correct and complete copies of all written contracts referenced in the Wellmont Counsel Memorandum and true and complete summaries of any oral contracts or other arrangements therein referenced have been made available to MSHA.

Section 3.08 Tax Matters. For purposes of this Section:

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

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

(c) Wellmont and the Wellmont Subsidiaries will have timely filed all federal income tax returns and all other material Tax Returns that they are required to file on or before the Effective Date. All such Tax Returns are correct and complete in all material respects. All material Taxes due and owing by Wellmont and the Wellmont Subsidiaries have been paid or reserved against in such party's Financial Statements. Neither Wellmont nor the Wellmont Subsidiaries currently are the beneficiary of any extension of time within which to file any Tax Return except as set forth in the Wellmont Counsel Memorandum. No written claim has been made within the last 3 years by an authority in a jurisdiction where Wellmont or the Wellmont Subsidiaries do not file Tax Returns that they are or may be subject to taxation by that jurisdiction.

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

(e) There is no material dispute or claim concerning any Tax liability of Wellmont or any entity listed in Schedule 3.03 of the Wellmont Counsel Memorandum either: (i) claimed or raised by any governmental authority in writing and brought to the attention of any of the directors, officers, or employees responsible for Tax matters of Wellmont and the Wellmont Subsidiaries; or (ii) as to which any of the directors, officers, or employees responsible for Tax matters of Wellmont and the Wellmont Subsidiaries has knowledge based upon personal contact with any agent of such governmental

authority. Except as disclosed in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries is the subject of an audit or examination by any governmental authority with respect to its potential liability for Taxes.

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

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

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

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

Section 3.09 Title to Properties. 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

restrictions other than; (a) those incurred in the ordinary course of Wellmont's business, including those related to debt obligations of Wellmont reflected in the Financial Statements, and (b) "Permitted Liens." For the purposes of this Agreement, "Permitted Liens" shall mean: (i) easements that do not materially adversely affect the full use and enjoyment of the Owned Real Property (as defined in Section 3.13 below) or Leased Real Property (as defined in Section 3.13 below) for the purposes for which it is currently used or materially detract from its value; (ii) imperfections of title and encumbrances, if any, individually or in the aggregate, which are not material, do not materially detract from the marketability or value of the properties subject thereto, and do not materially impair the operations of the owner thereto; (iii) liens for taxes not yet due and payable; and (iv) liens incurred in the ordinary course of business in connection with governmental insurance or benefits or to secure performance of leases and contracts (other than for borrowed money) which liens do not, individually or in the aggregate, materially and adversely affect the full use and enjoyment of the properties to which they are attached.

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

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

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

available to MSHA correct and complete copies of all such permits, consents, orders, approvals, and licenses. A list of all permits, licenses, orders, and approvals held by Wellmont and the Wellmont Subsidiaries is set forth in the Wellmont Counsel Memorandum.

Section 3.13 Real Property.

(a) Owned. 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.

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

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

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

(e) There have been no prohibited transactions with respect to any Plan which could result in liability to the Representing Party, any of the Wellmont Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. There has been no breach of fiduciary duty (including violations under Part 4 of Title I of ERISA) with respect to any Plan which could result in liability to the Representing Party, any of the Wellmont Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. No action, suit, proceeding, hearing, or investigation relating to any Plan

(other than routine claims for benefits) is pending or has been threatened, and neither Wellmont nor any of the Wellmont Subsidiaries, nor any of their respective employees, has knowledge of any fact that would reasonably be expected to form the basis for such action, suit, proceeding, hearing, or investigation. Except as set forth in the Wellmont Counsel Memorandum, no matters are currently pending with respect to any Plan under the Employee Plans Compliance Resolution System maintained by the Internal Revenue Service or any similar program maintained by any other government authority.

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

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

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

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

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

(k) Except as reflected in the Wellmont Counsel Memorandum, each Plan sponsored by Wellmont or any of the Wellmont Subsidiaries is terminable at the discretion of such entity with no more than 30 days' advance notice and without material cost to such entity. Wellmont and any of the Wellmont Subsidiaries may, without

material cost, withdraw their employees, directors, officers, and consultants from any Plan which is not sponsored by such entity. Except as reflected in the Wellmont Counsel Memorandum, no Plan has any provision which could increase or accelerate benefits or any provision which could increase liability to MSHA as a result of the transactions contemplated hereby, alone or together with any other event. Except as reflected in the Wellmont Counsel Memorandum, no Plan imposes withdrawal charges, redemption fees, contingent deferred sales charges, or similar expenses triggered by termination of the plan or cessation of participation or withdrawal of employees thereunder. No officer, trustee, agent, or employee of Wellmont or any of the Wellmont Subsidiaries has made any oral or written representation which is inconsistent with the terms of any Plan which may be binding on such Plan, the Representing Party, or any of the Wellmont Subsidiaries.

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

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

Section 3.17 Medicare Participation/Accreditation.

(a) For purposes of this Section:

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

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

(b) All hospitals and other health care providers owned or operated as continuing operations by Wellmont or any Wellmont Subsidiary (each, a "Wellmont Facility," and together, the "Wellmont Facilities") that make claims for payment under Title XVIII of the Social Security Act ("Medicare") and Title XIX of the Social Security Act ("Medicaid") are eligible to receive payment without restriction under Medicare and Medicaid, and each of them is a "provider" or "supplier" with valid and current provider agreements and with one or more provider numbers with the federal Medicare program and the Medicaid program of Tennessee or Virginia (the "Government Programs") through a contractor, a fiscal intermediary, or a carrier, as applicable. Each of the Wellmont Facilities that makes claim for payment under TRICARE programs is a "provider" with valid and current provider agreements and with one or more provider numbers with TRICARE. Each Wellmont Facility is in compliance with the conditions of participation for the Government Programs and TRICARE in all material respects and

has received all approvals or qualifications necessary for capital reimbursement of the assets of Wellmont or a Wellmont Subsidiary, except where the failure to be in such compliance or to have such approvals or qualifications would not individually or in the aggregate have a Material Adverse Effect on Wellmont or on any of the Wellmont Subsidiaries. There is not pending, nor to the Knowledge of Wellmont, threatened, any proceeding or investigation under the Government Programs or TRICARE involving Wellmont or the Wellmont Facilities. The cost reports of Wellmont and the Wellmont Facilities for the Government Programs for the fiscal years through June 30, 2014 and for subsequent periods that are required to be filed on or before the Effective Date have been or will be properly filed and, to the Knowledge of Wellmont, are or will be complete and correct in all material respects. Wellmont and the Wellmont Subsidiaries are in material compliance with filing requirements with respect to cost reports of the Wellmont Facilities and, to the Knowledge of Wellmont, such reports do not claim, and none of the Wellmont Facilities have received payment or reimbursement in excess of the amount provided by federal or state law or any applicable agreement, except where excess reimbursement was noted on the cost report. Except for claims, actions, and appeals in the ordinary course of business, there are no material claims, actions, or appeals pending before any commission, board, or agency, including any contractor, fiscal intermediary, or carrier, or Governmental Entity, with respect to any Government Program cost reports or claims filed with respect to the Wellmont Facilities, on or before the date of this Agreement, or any disallowances by any commission, board, or agency in connection with any audit of such cost reports.

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

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

(e) Neither Wellmont nor any of the Wellmont Subsidiaries nor (to the Knowledge of Wellmont) any member, trustee, officer, or employee of Wellmont or any of the Wellmont Subsidiaries, nor any agent acting on behalf of or for the benefit of any of the foregoing, has directly or indirectly in connection with any of the Wellmont Facilities; (i) offered or paid, solicited or received, any remuneration, in cash or in kind, to or from, or made any financial arrangements with, any past, present, or potential customers, past or present suppliers, patients, physicians, contractors, or third party payors of Wellmont or any of the Wellmont Facilities in order to induce referrals or

otherwise generate business or obtain payments from such Persons to the extent any of the foregoing is prohibited by federal or state law; (ii) given or agreed to give, or is aware that there has been made or that there is any agreement to make, any gift or gratuitous payment of any kind, nature, or description (whether in money, property, or services) to any customer or potential customer, supplier, or potential supplier, contractor, third party payor, or any other Person to the extent any of the foregoing is prohibited by federal or state law; (iii) made or agreed to make, or is aware that there has been made, or that there is any agreement to make, any contribution, payment, or gift of funds or property to, or for the private use of, any governmental official, employee, or agent where either the contribution, payment, or gift or the purpose of such contribution, payment, or gift is or was illegal under the laws of the United States or under the law of any state or any other Governmental Entity having jurisdiction over such payment, contribution, or gift; (iv) established or maintained any unrecorded fund or asset for any purpose or made any misleading, false, or artificial entries on any of its books or records for any reason; or (v) made, or agreed to make, or is aware that there has been made, or that there is any agreement to make, any payment to any Person with the intention or understanding that any part of such payment would be used for any purpose other than that described in the documents supporting such payment.

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

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

Section 3.18 Minute and Stock Transfer Books. The minute books of Wellmont and the Wellmont Subsidiaries are true, correct, complete, and current in all material respects, and contain accurate and complete records of all material actions taken by their respective Boards of Directors, Members or Managers and, in the case of for-profit Wellmont Subsidiaries, their respective shareholders. All signatures contained in such minute books are the true signatures of

the persons whose signatures they purport to be. The stock (or other equity) transfer books of each for-profit Wellmont Subsidiary are true, correct, complete, and current in all respects.

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

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

Article IV Representations and Warranties of MSHA.

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

Section 4.01 Effect of Agreement. Assuming the due execution and delivery of this Agreement by Wellmont, this Agreement is a legal, valid, and binding obligation of MSHA and is enforceable against it in accordance with its terms, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other laws affecting creditors' rights generally and except as enforceability may be subject to general principles of equity. Except as set forth in a confidential communication delivered by MSHA legal counsel to Wellmont legal counsel prior to the date of this Agreement (the "MSHA Counsel Memorandum"), the execution, delivery and performance of this Agreement by MSHA are within its corporate powers. Except as set forth in the MSHA Counsel Memorandum, or otherwise expressly provided in this Agreement, the execution, delivery, and performance of this Agreement by MSHA and the consummation of the transactions contemplated hereby by MSHA will not: (i) require the consent, approval, or authorization of any person, corporation, partnership, joint venture, or other business association or public authority; (ii) violate any provisions of law applicable to MSHA or to any of the MSHA Subsidiaries now or immediately prior to the Effective Date; (iii) with or without the giving of notice or the passage of time, or both, conflict with or result in a breach or termination of any provision of, or constitute a material default under, or result in the creation of any lien, charge, or encumbrance upon any of the properties or assets of MSHA or any of the MSHA Subsidiaries pursuant to, any corporate charter, bylaw, indenture, note, bond, pledge, mortgage, deed of trust, lease, license, contract, agreement, commitment, or other instrument or obligation, or any order, judgment, award, decree, statute, ordinance, or regulation, to which MSHA or any of the MSHA Subsidiaries is a party or by which MSHA or any of the MSHA Subsidiaries or any of their respective material assets or properties may be bound; or (iv) result in the acceleration of any indebtedness of MSHA or any of the MSHA Subsidiaries or increase the rate of interest payable by MSHA or by any of the MSHA Subsidiaries with respect to any indebtedness.

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

Section 4.03 MSHA Subsidiaries. Other than as disclosed in Schedule 4.03 of the MSHA Counsel Memorandum, MSHA does not directly or indirectly own any interest in any other corporation, partnership, joint venture, or other business association or entity, foreign or domestic. Such corporations, partnerships, joint ventures, or other business entities set forth in

the MSHA Counsel Memorandum of which it owns, directly or indirectly, more than fifty percent (50%) of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests) are referred to herein each as a "MSHA Subsidiary" or collectively as "MSHA Subsidiaries." Set forth in the MSHA Counsel Memorandum is an indication of the interest owned by MSHA in each corporation, partnership, joint venture, or other business association or entity in which MSHA owns any of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests). With respect to the MSHA Subsidiaries, MSHA on behalf of itself and the MSHA Subsidiaries, represents and warrants the following:

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

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

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

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

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

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

Section 4.04 Financial Statements. MSHA has delivered to Wellmont, or will deliver to Wellmont within five (5) days of becoming available, copies of (i) its audited consolidated financial statements for the years ended June 30, 2013 and June 30, 2014 and for each year thereafter through the Effective Date, as presented by the auditors regularly retained by MSHA, together with any management letters issued by the auditors in connection with the foregoing and

a written copy of all material presented to the Audit Committee of the MSHA Board, and (ii) its unaudited interim consolidated financial reports for the year ended June 30, 2015, and the two months ended August 31, 2015 and each month thereafter through the Effective Date. Such financial statements, together with the notes thereto, and such interim unaudited consolidated financial reports (collectively, the "Financial Statements"), are in accordance with the books and records of MSHA; and except as otherwise set forth in the MSHA Counsel Memorandum, fairly present in all material respects the financial position of MSHA and the results of operations and cash flows for the years then ended or other periods indicated in conformity with GAAP applied on a consistent basis throughout such periods, except to the extent that the interim unaudited consolidated financial reports contain no notes and are subject to year-end audit adjustments that are not, individually or in the aggregate, material and, except as noted in such statements, consistent with prior periods. The most recent balance sheet of MSHA included in its Financial Statements is referred to herein as its "Balance Sheet." The "Balance Sheet Date" shall mean June 30, 2015.

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

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

Section 4.07 Contracts. The MSHA Counsel Memorandum contains a list of all contracts, agreements, commitments, and arrangements to which MSHA or any of the MSHA Subsidiaries are a party or by which any of their assets are bound or affected that: (i) involve the expenditure by MSHA or any of the MSHA Subsidiaries thereto of more than $250,000 on an annual basis; (ii) to the Knowledge of MSHA, are with, or relate to, any physician; or (iii) to the Knowledge of MSHA, are with, or relate to, any Disqualified Person within the meaning of Section 4958(f) of the Code (each a “MSHA Material Contract”). "Knowledge of MSHA" when used in this Agreement means the actual knowledge of the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or the General Counsel of MSHA. For avoidance of doubt, the term Disqualified Person shall include persons (including any physicians or their family members) who are or were, at any time during the five-year period ending on the Effective Date: (a) voting members of the subject organization’s governing body; (b) presidents, chief executive officers, chief operating officers, and other persons with ultimate responsibility for implementing the decisions of the governing body or for supervising the management, administration, or operation of the organization, regardless of title; (c) treasurers and chief financial officers and other persons with ultimate responsibility for managing the finances of the

organization, regardless of title; (d) in a position to exercise substantial influence over the subject organization's affairs, including (i) persons who have or share authority to control or determine a substantial portion of the organization's capital expenditures, operating budget, or compensation for employees, (ii) persons who manage a discrete segment or activity of the organization that represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole, (iii) persons who are substantial contributors to the organization (within the meaning of Code Section 507(d)(2)(A)), taking into account only contributions received by the organization during its current taxable year and the four preceding taxable years; and (iv) persons whose compensation is primarily based on revenues derived from activities of the organization, or of a particular department or function of the organization, that the person controls; (e) family members of persons meeting a definition in (a)-(d) above (for this purpose, "family members" are limited to the following: spouse, brothers or sisters (by whole or half-blood), spouses of brothers or sisters (by whole or half-blood), ancestors, children, grandchildren, great grandchildren, and spouses of children, grandchildren, and great grandchildren); and (f)(i) a corporation in which persons described in (a)-(e) own more than 35 percent of the combined voting power; (ii) a partnership in which persons described in (a)-(e) own more than 35 percent of the profits interests; or (iii) a trust or estate in which persons described in (a)-(e) own more than 35 percent of the beneficial interests. Other than as set forth in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries has entered into any MSHA Material Contract. All MSHA Material Contracts are valid and enforceable in accordance with their terms, except as such enforceability may be limited by bankruptcy, insolvency, receivership, and other laws affecting creditors' rights generally and general principles of equity. MSHA and the MSHA Subsidiaries and, to the Knowledge of MSHA, all other parties to each of the foregoing arrangements, have performed in all material respects their respective obligations to date required to be performed under each MSHA Material Contract. Except as disclosed in the MSHA Counsel Memorandum, neither MSHA or any of the MSHA Subsidiaries nor, to the Knowledge of MSHA, any other party, is in default or in arrears in any material respect under the terms of any of the foregoing arrangements, and no condition exists or event has occurred that, with the giving of notice or the lapse of time or both, would constitute a material default under any of them. Except as noted to the contrary in the MSHA Counsel Memorandum, none of the rights of MSHA or any of the MSHA Subsidiaries under any of such agreements is subject to termination or modification as the result of the transactions contemplated by this Agreement. Correct and complete copies of all written contracts referenced in the MSHA Counsel Memorandum and true and complete summaries of any oral contracts or other arrangements therein referenced have been made available to Wellmont.

Section 4.08 Tax Matters. For purposes of this Section:

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

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

(c) MSHA and the MSHA Subsidiaries will have timely filed all federal income tax returns and all other material Tax Returns that they are required to file before the Effective Date. All such Tax Returns are correct and complete in all material respects. All material Taxes due and owing by MSHA and the MSHA Subsidiaries have been paid or reserved against in such party's Financial Statements. Neither MSHA nor the MSHA Subsidiaries currently are the beneficiary of any extension of time within which to file any Tax Return except as set forth the MSHA Counsel Memorandum. No written claim has been made within the last 3 years by an authority in a jurisdiction where MSHA or the MSHA Subsidiaries do not file Tax Returns that they are or may be subject to taxation by that jurisdiction.

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

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

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

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

(h) The unpaid Taxes of MSHA and the MSHA Subsidiaries: (i) did not, as of the Balance Sheet Date, exceed by any material amount the reserve for Tax liability (excluding any reserve for deferred Taxes established to reflect timing differences between book and Tax income) set forth on the face of the Balance Sheet as of the

Balance Sheet Date (rather than in any notes thereto), and (ii) will not exceed by any material amount that reserve as adjusted for the passage of time through the Effective Date in accordance with the past custom and practice of MSHA and the MSHA Subsidiaries in filing its Tax Returns.

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

Section 4.09 Title to Properties. 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,

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

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

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

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

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

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

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

Section 4.15 Insurance. Other than as set forth in the MSHA Counsel Memorandum, MSHA and the MSHA Subsidiaries maintain in force valid, binding, and enforceable insurance policies providing adequate coverage for all risks normally insured against by others in the businesses of MSHA and the MSHA Subsidiaries. All premiums due thereon have been paid

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

Section 4.16 Employees; Benefit Plans.

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

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

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

(d) MSHA has provided to Wellmont the latest actuarial valuation report for each Plan that is a defined benefit pension plan and the most recent information on contributions and the fair market value of the assets for each Plan. All financial and

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

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

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

(g) Except as disclosed in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries has ever sponsored, maintained, administered, contributed to, had any obligation to contribute to, or had any other liability under or with respect to any policy, agreement, practice, or Plan which provides health, life, or other coverage for former directors, officers, or employees (or any spouse or former spouse or

other dependent thereof), other than benefits required by COBRA or comparable state-mandated health plan continuation coverage.

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

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

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

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

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

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

Section 4.17 Medicare Participation/Accreditation.

(a) For purposes of this Section:

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

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

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

(c) Except as set forth in the MSHA Counsel Memorandum or disclosed to Wellmont prior to the date hereof through the Black Box Process, to the Knowledge of

MSHA, all billing practices of MSHA and the MSHA Subsidiaries with respect to the MSHA Facilities to all third party payors, including the Government Programs, TRICARE, and private insurance companies, have been in compliance with all applicable federal and state laws, regulations, and polices of such third party payors and Government Programs in all material respects, and (to the Knowledge of MSHA) neither MSHA nor the MSHA Facilities have billed or received any payment or reimbursement in excess of amounts allowed by state or federal law.

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

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

(f) Neither MSHA nor any of the MSHA Subsidiaries, nor (to the Knowledge of MSHA) any member, trustee, officer, or employee of MSHA nor any of the MSHA Subsidiaries, is a party to any contract, lease agreement, or other arrangement (including any joint venture or consulting agreement) related to MSHA or any of the MSHA Facilities with any physician, health care facility, hospital, nursing facility, home health agency, or other Person who is in a position to make or influence referrals to or otherwise generate business for MSHA with respect to any of the MSHA Facilities, to provide

services, lease space, lease equipment, or engage in any other venture or activity, to the extent that any of the foregoing is prohibited by any federal or state law.

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

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

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

Section 4.20 No Other Representations or Warranties. None of MSHA nor any affiliate thereof, nor any of their agents (financial, legal or otherwise), makes or has made any representations or warranties, express or implied, of any nature whatsoever relating to MSHA or the MSHA Subsidiaries or the business of MSHA and the MSHA Subsidiaries or otherwise in connection with the transactions contemplated by this Agreement, other than those representations and warranties of MSHA expressly set forth in this ARTICLE II. MSHA hereby expressly disclaims, and Wellmont acknowledges that it is not relying on, any other express or implied representations or warranties with respect to any matter whatsoever, including any express or implied representation or warranty as to the completeness of the information contained in this Agreement. Without limiting the generality of the foregoing, Wellmont acknowledges that none of MSHA nor any affiliate or agents thereof has made, and shall not be deemed to have made, any representations or warranties, express or implied, in, or concerning the accuracy or completeness of, the materials relating to the business of MSHA and the MSHA Subsidiaries made available to Wellmont and its affiliates and agents, including due diligence materials, or in any presentation about the business of MSHA and the MSHA Subsidiaries by MSHA, management of MSHA or others in connection with the transactions contemplated by this Agreement, and no statement contained in any of such materials or made in any such presentation shall be a representation or warranty hereunder or otherwise or be relied upon by Wellmont in executing, delivering and performing this Agreement. Wellmont acknowledges that any cost estimates, projections or other predictions, any data, any future financial information or

any memoranda or offering materials or presentations, including but not limited to, any confidential information memorandum or similar materials made available by Wellmont, its affiliates or agents are not and shall not be deemed to be or to include representations or warranties of Wellmont, and are not and shall not be relied upon by MSHA or its affiliates in executing, delivering and performing this Agreement. Furthermore, Wellmont and MSHA each hereby acknowledge that this Agreement embodies the justifiable expectations of sophisticated parties derived from arm's-length negotiations; all parties to this Agreement specifically acknowledge that no party has any special relationship with another party that would justify any expectation beyond that of an ordinary buyer and an ordinary seller in an arm's-length transaction.

Article V Pre-Effective Date Covenants and Regulatory Approvals.

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

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

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

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

(iv) make or solicit offers for, or hold discussions or negotiations or enter into any agreement with respect to, (a) the sale, lease or management of any of its hospitals or any material portion of its assets or any ownership interest in any entity owning any of its hospitals or any material portion of its assets, (b) any reorganization, merger, consolidation, management agreement, member substitution or joint venture involving any of its hospitals or any material portion of its assets, or (c) any other transaction in which a person or group other than MSHA would acquire the right, directly or indirectly, to control the governing board of, direct the operations of, establish governing or operating policies for, and/or own, lease or otherwise acquire the right to use or control, any of its hospitals or any material portion of its assets, or provide information to any person who may be interested in any of the foregoing, or permit any trustee, officer, employee, agent, or other affiliate to do any of the foregoing.

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

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

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

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

(iv) make or solicit offers for, or hold discussions or negotiations or enter into any agreement with respect to, (a) the sale, lease or management of any

of its hospitals or any material portion of its assets or any ownership interest in any entity owning any of its hospitals or any material portion of its assets, (b) any reorganization, merger, consolidation, management agreement, member substitution or joint venture involving any of its hospitals or any material portion of its assets, or (c) any other transaction in which a person or group other than Wellmont would acquire the right, directly or indirectly, to control the governing board of, direct the operations of, establish governing or operating policies for, and/or own, lease or otherwise acquire the right to use or control, any of its hospitals or any material portion of its assets, or provide information to any person who may be interested in any of the foregoing, or permit any trustee, officer, employee, agent, or other affiliate to do any of the foregoing.

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

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

(b) The Parties recognize that disclosure of certain information may raise unique legal concerns due to the proximity of the Parties' operations and facilities ("Competitive Sensitive Information"). Such Competitive Sensitive Information may include, but is not limited to, information about prices, pricing formulas, costs, rates of provider compensation, strategy or intentions regarding contracting with any provider or purchaser, fee schedules, managed care contracts, premium rates, compensation or benefits information relating to employees, recruitment of medical professionals or others, future expansion plans involving clinical services or pertaining to physicians, and any non-public marketing or strategic planning documents or other competitively sensitive documents relating to a Party's future plans. The Parties will only disclose Competitive Sensitive Information in accordance with law as agreed to in advance by the Parties and their respective legal counsel and to that end, the Parties may enter into one or more protective agreements or develop other arrangements to address the review of such Competitive Sensitive Information to ensure compliance with applicable law.

(c) Subject to subsection (b) above, each of Wellmont and MSHA shall afford to the other Party and such Party's representatives full access to its properties, books, and records and those of its Subsidiaries during normal business hours in order that each Party may have full opportunity to make such reasonable investigation as it desires of the affairs of the other Party and its Subsidiaries, provided that such Party's right of access and inspection shall not interfere unreasonably with the business or operations of the other Party. Neither Party (nor such Party's representatives) will contact the employees or other personnel of the other Party (including without limitation members of the medical staffs of such Party's hospitals), and no inspection will be conducted, without such party first coordinating such inspection or contact with, in the case of Wellmont, Gary Miller, Esq. or his designees and in the case of MSHA, Tim Belisle, Esq. or his designees.

(d) Except as and to the extent required by law, without the prior written consent of the other Party, neither MSHA nor Wellmont shall, and each shall direct its representatives not to, directly or indirectly, make any public comments, statement or communication with respect to, or otherwise disclose or permit the disclosure of the existence of discussions regarding the Affiliation or any of the terms, conditions or aspects of the Affiliation except in the manner provided by the Confidentiality Agreement. The timing, content and context of any announcements, press releases, public statements, or reports and related matters incident to the matters referenced in this term sheet, or its existence, will be determined in advance by the mutual written consent of the Parties. Further, the Parties will advise each other of communications to their employees and medical staff relating to the Affiliation prior to the communication of the same.

Section 5.05 Regulatory Filings; Efforts to Close. Unless and until this Agreement is terminated pursuant to Article VIII, each of MSHA and Wellmont shall exercise reasonable diligence to: (a) make or obtain all consents, approvals, authorizations, registrations, and filings with all Governmental Entities or administrative agencies as are required in connection with the consummation of the transactions contemplated by this Agreement; (b) provide such other information and communications to any Governmental Entity as MSHA, Wellmont, or such Governmental Entities may reasonably request; and (c) otherwise take such actions necessary to satisfy all conditions to Closing and to Close. Without limiting the generality of the foregoing, MSHA and Wellmont shall, as promptly as practicable and in cooperation with each other, to the extent required by law, complete and file with the appropriate authorities the notification forms and any other documents, and provide such information, as required under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR"), the Tennessee Public Benefit Hospital Sales and Conveyance Act of 2006, §§55-531 et seq. of the Code of Virginia, and the Government Programs. MSHA and Wellmont will, and will cause their respective counsel to, supply to each other copies of all material correspondence, filings or written communications by such party or its Affiliates with any Governmental Entity or staff members thereof, with respect to the Affiliation. Neither Party shall be required to affirmatively sue any applicable governmental agency in order to obtain the regulatory approvals required by Sections 6.05 and 7.05, nor shall either party be required to defend any action or proceeding by or before any court or other governmental body or agency which seeks to restrain, prohibit, or invalidate the transactions contemplated by this Agreement.

Section 5.06 Cooperative Agreement.

(a) The Parties deem this Agreement to be their "cooperative agreement" as defined in the Tennessee Hospital Cooperation Act of 1993, as amended (the "Tennessee COPA Act") and § 15.2-5369 of the Code of Virginia (the "Virginia COPA Act" and together with Tennessee COPA Act, the "COPA Acts").

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

(collectively, the "Approvals"). Each of Wellmont and MSHA shall exercise reasonable diligence to obtain the Approvals.

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

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

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.

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.

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.

(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

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

Integration Council to disband upon the Effective Date or for it to perform any specified functions post-Closing serving in the capacity of an advisory council to the Initial Management Team.

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

(a) The establishment of a long-term strategy for improving the health status of the region served by the merged system that supports both the Tennessee and Virginia state health plans;

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

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

(d) Establishment of programs to improve health literacy;

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

(f) Growth of medical research programs; and

(g) Expansion of academic opportunities, to include, but not be limited to, expansion of new fellowships and other opportunities to allow physicians and allied health professionals to train and serve in health professional shortage areas within the region served by Parent Company and its Affiliates.

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

Section 9.05 Clinical Council.

(a) Promptly after the Closing, Parent Company will develop a physician-led clinical council (the "Clinical Council") (composed of appropriate balances of private physicians, group practice physicians and employed physicians whose initial composition is determined by the Parent Company Board of Directors) to guide, advise and assist in implementation of a plan to integrate clinical activities, service lines and business units, and to advise on any appropriate further clinical integrative actions post-implementation that would result in added growth, operational efficiencies and advancements in patient care. The initial Clinical Council will equally represent physicians whose primary practice venue is Wellmont or MSHA.

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

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

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

Section 9.07 Employees.

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

(b) Parent Company will honor prior service credit under each Parties' employee plans for purposes of eligibility and vesting under the employee benefit plans maintained by Wellmont and MSHA, and will waive any eligibility requirement or pre-existing condition limitation for persons covered under each Parties' employee benefit

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

(c) Parent Company will work as quickly as practicable after closing to address any required actions with respect to differences in salary/ pay rates and employee benefit structures with a goal of creating consistency throughout the merged health system wherever feasible.

Section 9.08 Medical Staffs; Physician Contracts.

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

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

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

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

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

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

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

Article X Miscellaneous Provisions.

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

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

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

Section 10.04 Expenses; Termination Payment.

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

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

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

(d) On 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.

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

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

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

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

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

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

Section 10.10 Execution in Counterparts. This Agreement may be executed in more than one counterpart, each of which shall be deemed to be an original, but all of which shall be deemed to constitute one instrument. It shall not be necessary for all parties to have signed the same counterpart provided that all parties have signed at least one counterpart.

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

Wellmont: Wellmont Health System
1905 American Way

Kingsport, Tennessee 37660
Attn: Bart Hove, President & CEO

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

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

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

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

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

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

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

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

Section 10.13 Public Announcement. Except as and to the extent required by law, without the prior written consent of the other party, neither MSHA nor Wellmont shall, and each shall direct its representatives not to, directly or indirectly, make any public comments, statement or communication with respect to, or otherwise disclose or permit the disclosure of the existence of this Agreement or any of the terms, conditions or aspects of this Agreement except in the manner provided by the Confidentiality Agreement. The timing, content and context of any announcements, press releases, public statements, or reports and related matters incident to the matters referenced in this term sheet, or its existence, will be determined in advance by the mutual written consent of the Parties. Further, the Parties will advise each other of communications to their employees and medical staff relating to the transactions contemplated by this Agreement prior to the communication of the same.

Section 10.14 Construction and Certain Definitions.

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

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

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

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

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

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

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

[Signature page follows]

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

WELLMONT HEALTH SYSTEM

By: _____
Roger Leonard
Chairman of the Board of Directors

_____
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)

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

WELLMONT AFFILIATES

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

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

- WPS Providers, Inc. (100%)

EXHIBIT B

Shared Vision and Guiding Principles

A Shared Vision for Regional Healthcare

It is the shared vision of our boards that Wellmont Health System and Mountain States Health Alliance come together as equal partners to develop a brand new health system for our region with a new leadership structure, a new board, a new name, and a new kind of vision. This new leadership structure and board will work to unite the resources of both systems with one common purpose—to become one of the best regional health systems in the nation.

As one of the largest health systems and employers in the state of Tennessee, this new system will—

- Establish new unifying mission, vision, and values statements that honor our heritage and charter our future
- Be one of the strongest health systems in the country, known for outstanding clinical outcomes and superior patient experiences
- Be one of the best health system employers in the country and one of the most attractive health systems for physicians and employee team members
- Create new models of joint physician and administrative leadership to shape the future of healthcare in our region through substantial physician influence and direction
- Partner with physicians to achieve better quality at lower cost for patients, businesses, and payers
- Achieve long-term financial stability and sustainability through wise stewardship of resources, avoidance of waste, and sound fiscal management
- Advance high-level services so that more people can receive the care they need close to home
- Be a national model for rural healthcare delivery and rural access to care
- Work with regional educational and allied health partners to identify health gaps and disparities and effectively meet community health needs
- Create an efficient, high quality healthcare system that attracts employers to our region and creates long-term economic opportunity
- Build new population health models and leverage electronic health records and community engagement programs to reduce unhealthy behaviors and improve the overall health status of our region
- Work with academic partners, in particular East Tennessee State University, in new ways to bolster medical school and allied health programs and attract research investments
- Establish innovative philanthropic partnerships for healthcare advancement

To accomplish these objectives, we will seek to build shared vision with our team members and physicians and invest in their success. As a health system of choice, the new system will benchmark against the best health systems in the nation to create an environment that advances our team members and physicians.

Our integration should be methodical and intentional, guided by achieving clear value for the community, our team members, and our physicians. A substantial period of initial assessment will be needed and will result in a long-term strategic vision for the new system. During the assessment and planning period, it will be important to maintain clinical services in our current communities and move forward to address any access gaps across the region. We commit to open communication through rotating quarterly town hall meetings and other methods to keep our communities and physicians informed about our plans and our progress.

Working together, focused solely on what is in the best interests of our physicians, team members, patients, and communities we will set a new standard for healthcare excellence and bring unprecedented value to our region guided by the principles that follow.

Guiding Principles for a New Regional Health System

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

Mission, Vision, and Strategy

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

Patients

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

Physicians

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

Employees

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

Clinical Programs, Service, and Quality

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

Management & Operations

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

Investment and Innovation

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

Population Health Management

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

Governance

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

EXHIBIT C-1

Interim Parent Company Articles and Interim Parent Company Bylaws

EXHIBIT C-2

Interim Directors and Interim Officers

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

Officers:

President: Alan Levine

Secretary/Treasurer: Alice Pope

EXHIBIT C-3

Amended Parent Company Articles

EXHIBIT C-4

Amended Parent Company Bylaws

EXHIBIT D-1

Parent Company Board Officers and Initial Management Team

Board Officers shall be:

(i) Executive Chairman/President: Alan Levine

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

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

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

(v) Chief Executive Officer: Bart Hove

The Initial Management Team shall be:

(i) Executive Chairman/President: Alan Levine

(ii) Chief Executive Officer: Bart Hove

(iii) Chief Operating Officer: Marvin Eichorn

(iv) Chief Financial Officer: Alice Pope

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

EXHIBIT D-2

Position Description of Executive Chairman/President

Leadership

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

Meeting

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

Directors

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

Induction, Development and Performance Evaluation

- Ensuring new directors are oriented, and provided adequate opportunity to on-board.
- Ensuring that the development needs of directors are identified and met. The directors should be able to continually update their skills, knowledge, and familiarity with the company.
- In conjunction with the Vice Chair, identifying the development needs of the board as a whole to enhance its overall effectiveness as a team and to ensure it receives board education consistent with industry standards for a system of the size and scope of the Corporation.
- Ensuring the performance of the board, its committees and individual directors is evaluated periodically through the Board Governance Committee, and acting on the results of such evaluation.

Relations with Stakeholders

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

Direct Reports

The direct reports to the Executive Chairman/President include:

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

Other Responsibilities

The Executive Chairman/President shall:

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

The Executive Chairman/President is accountable to, and reports to the Corporation's Board.

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

- Enhancement of external affiliations and relationships.
- Implementing and oversight of compliance with Certificate of Public Advantage or other regulatory agreements.
- Regular review of the operational performance of the company.
- Responsible to the Corporation Board for ensuring the provision of the highest quality of patient care and customer service in all the Corporation facilities and business units.
- Responsible for management of the organization's debt.

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

EXHIBIT D-3

Position Description of CEO

Leadership

- The Chief Executive Officer of the Corporation reports to the Executive Chairman/President and is the senior executive in charge of all business operations of the Corporation organization. This executive position requires a combination of operational excellence and system administrative skills and must be attentive to enhanced financial performance in a physician-empowered culture. It is expected that the CEO is adroit in physician relations, physician recruitment and retention.

- This position requires visionary leadership and plays a vital role in creating, implementing and executing the strategy in conjunction with the Executive Chairman/President. Of paramount importance, this position requires the incumbent to establish credibility with employees, physicians, payors, providers and community leaders. The CEO is expected to raise the health system's visibility and reputation in the communities it serves in conjunction with the Executive Chairman/President.

- The CEO position serves as the principal operational leader for the organization and is responsible for driving forward the Corporation's vision to be the best healthcare delivery system in the region in conjunction with the Executive Chairman/President. This position is the champion for the Corporation's continued emphasis on "systemness" across the care delivery continuum, to achieve not only its quality and safety goals, but also to increase operational efficiency and provide a consistent point of service contact for its patients.

Major Responsibilities

- Possess a professional and personal adherence to the values, mission and philosophy of the Corporation organization.

- Expand on the legacy of the quality and safety of patient care services across the system.

- Working closely with the Executive Chairman/President to lead the ongoing review of the current strategic plan and development of future strategic plans; ensure the plan supports the organization's goal of clinical excellence, while at the same time considers the appropriate business model for the medical staff and strategic service opportunities for growth and addresses revenue generation to sustain ongoing growth. Realize the goal of an integrated health system that leverages the advantages of a multi-state and multimarket health.

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

Direct Reports

- Chief Operating Officer
- Chief Financial Officer

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

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

EXHIBIT D-4

Position Descriptions of COO and CFO

Chief Operating Officer

Leadership

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

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

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

Major Responsibilities

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

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

- Oversee major workforce and resource decisions.

- Develop new business strategies.

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

Direct Reports

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

Chief Financial Officer

Leadership

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

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

Major Responsibilities

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

- Foster relations between corporate entities

- Present to external audiences

Direct Reports

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

EXHIBIT E

Joint Board Task Force

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

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

EXHIBIT F

Integration Council

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

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

EXHIBIT G

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.28 “Interested Person” means with respect to any individual serving on or otherwise eligible to serve on the Parent Company Board of Directors, any committee of the Parent Company Board of Directors, the Board of Directors or any Board committee of MSHA, Wellmont, and any of their subsidiaries, that such individual fits within the published guidance issued by the Exempt Organizations Division of the Internal Revenue Service of the United States of America (the IRS EO Division) regarding which individuals are considered interested persons with respect to organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers.

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

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

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

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

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

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

terms of, or taking any action required by, this Agreement; (H) actions required to be taken by such Party under applicable law or contracts; or (I) the public announcement of this Agreement or the consummation of the transactions contemplated by this Agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit 11.2

Organizational Chart of Mountain States

Mountain States Health Alliance

Legal Structure

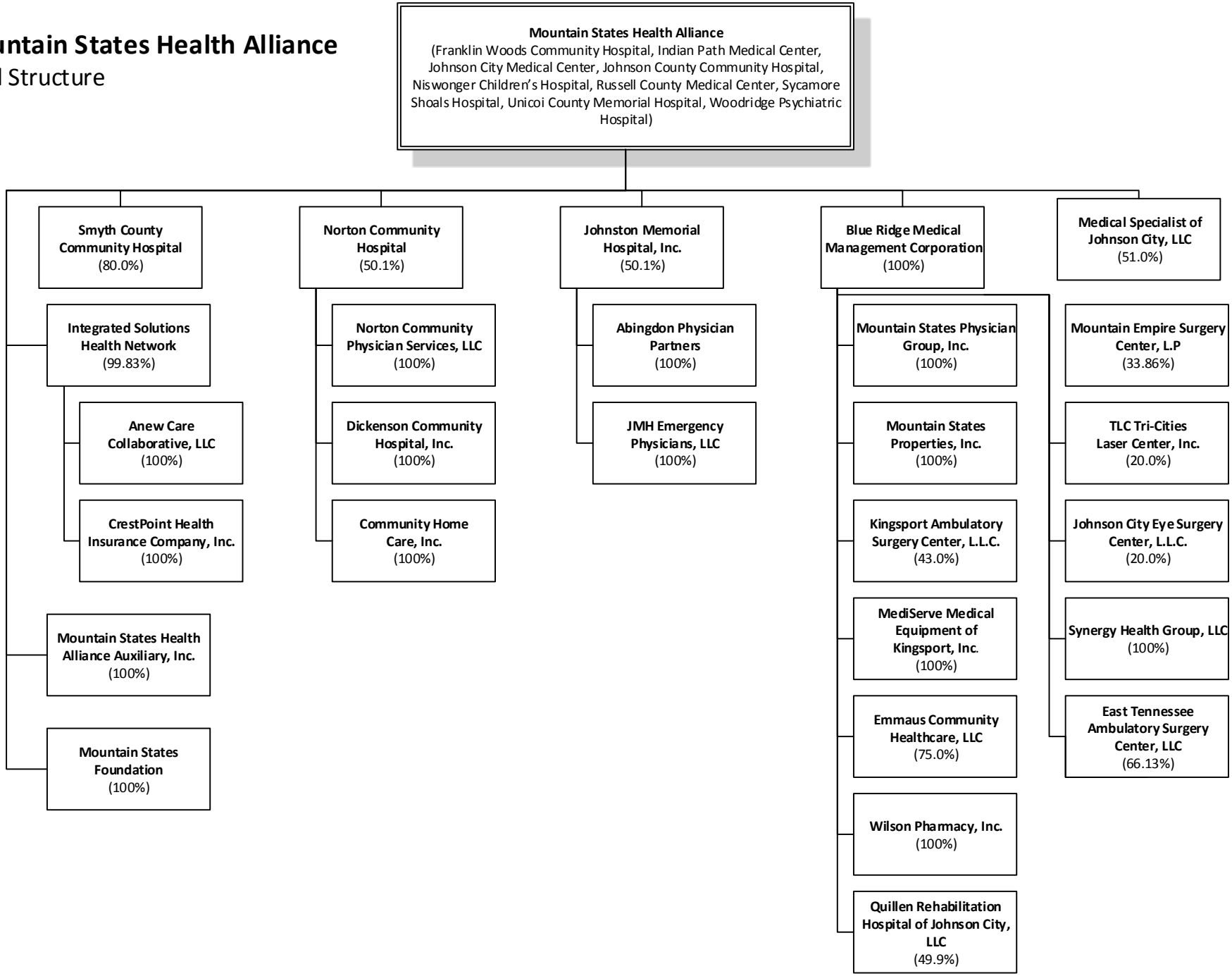
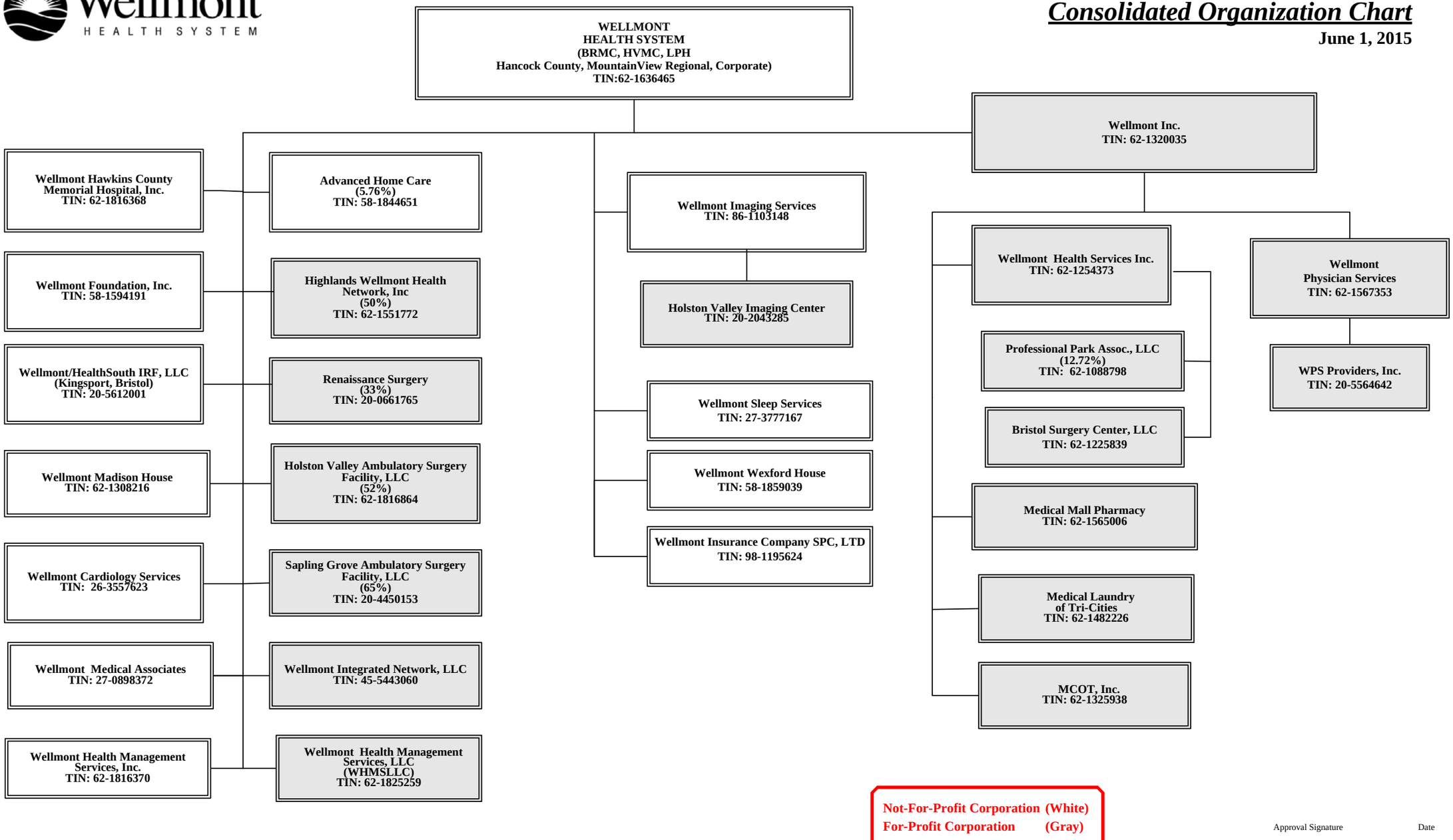


Exhibit 11.3

Organizational Chart of Wellmont

Wellmont Health System
Consolidated Organization Chart
June 1, 2015



Not-For-Profit Corporation (White)
For-Profit Corporation (Gray)

Approval Signature Date

Exhibit 11.4

Financial Summary for Mountain States

Mountain States Health Alliance Summary for the Fiscal Years Ended June 30, 2011 through June 30, 2015

Volumes:

Fiscal Year ended June 30, 2011:

As compared to fiscal 2010, inpatient admissions of 61,035 increased by 1.6%. Observation patients increased 13.8%, from 18,358 to 20,894. Total "patients in a bed" increased 4.4%, from 78,460 to 81,929. Deliveries increased 1.1%, from 4,461 to 4,511. Outpatient visits (inclusive of physician and urgent care clinics) declined slightly by 0.8% to 1,546,325. Emergency room visits decreased 3.3%, from 250,942 to 242,677; urgent care visits increased slightly by 0.7%.

Fiscal Year ended June 30, 2012:

As compared to fiscal 2011, inpatient admissions remained relatively flat with a slight increase of 119 or 0.2% to 61,154. Observation patients increased 6.2%, from 20,894 to 22,179. Total "patients in a bed" increased 1.7%, from 81,929 to 83,333. Deliveries declined 4.9%, from 4,511 to 4,288. Consistent with industry trends more volumes shifted from an inpatient to outpatient settings, outpatient visits (inclusive of physician and urgent care clinics) increased by 2.8% to 1,590,307. Emergency room visits increased by 1.7%, from 242,677 to 246,821; urgent care visits increased 11.5%.

Fiscal Year ended June 30, 2013:

As compared to fiscal 2012, inpatient admissions decreased by 3,051 or 5.0% to 58,103. Observation patients increased 6.2%, from 22,179 to 23,554. Total "patients in a bed" decreased 2.0%, from 83,333 to 81,657 primarily due to the implementation of accountable care organizations and high deductible health plans in our area. Deliveries increased by 0.4%, from 4,288 to 4,306. Outpatient visits (inclusive of physician and urgent care clinics) increased by 4.7% to 1,664,755. Emergency room visits increased by 1.1%, from 246,821 to 249,415; urgent care visits increased 23.2% due to a combined effect of an increase in utilization and the opening of a new location.

Fiscal Year ended June 30, 2014:

As compared to fiscal 2013, inpatient admissions continued to decline by 1,063 or 1.8% to 57,040. Observation patients increased 2.8%, from 23,554 to 24,218. Total "patients in a bed" decreased 0.5%, from 81,657 to 81,258. Surgeries increased by 2.6%. Deliveries decreased by 2.2%, from 4,306 to 4,213. Outpatient visits (inclusive of physician and urgent care clinics) increased by 1.7% to 1,693,521. Emergency room visits decreased by 3.9%, from 249,415 to 239,606; urgent care visits increased slightly by 0.1%

Fiscal Year ended June 30, 2015:

As compared to fiscal 2014, inpatient admissions increased by 5,009 or 8.8% to 62,049. Observation patients decreased 3.3%, from 24,218 to 23,407. Total "patients in a bed" increased 5.2%, from 81,258 to 85,456. Recent volume growth is attributed to a realization in pent-up demand as a result of several years of high deductible health plans as well as a strong flu season. Surgeries increased by 3.9%. Deliveries increased by 2.3%, from 4,213 to 4,312. Outpatient visits (inclusive of physician and urgent care clinics) increased by 2.9% to 1,742,769. Emergency room visits increased by 6.8%, from 239,606 to 255,857; urgent care visits increased by 10.8%.

Statement of Operations:

Fiscal Year ended June 30, 2011:

Due to increased volumes over fiscal 2010, net patient revenue increased $37.0 million or 4.0%. Total Revenue increased by $36.8 million or 3.9%.

Total Expenses increased $26.6 million or 2.8%. Salaries, contract labor, and benefits increased by $16.4 million or 3.5% driven by an increase in FTEs in patient care areas to support higher volume as well as an increase in employed providers. Supply costs decreased by $6.0 million or 3.4% driven by focused initiatives in supply chain. Fees increased by $3.4 million or 4.1% mainly as a result of higher physician fees. Depreciation increased by $19.1 million or 27.9% due to completion of a new hospital and several construction projects. Amortization expense decreased by $10.6 million due to the ASC 958-805 requirement for not-for-profit entities to cease amortization of goodwill and perform impairment testing in the future.

Income from operations of $25.8 million for fiscal 2011 increased $10.2 million over income from operations in fiscal 2010 of $15.6 million.

Fiscal Year ended June 30, 2012:

Net patient revenue increased $6.3 million or 0.7% over fiscal 2011. Other revenue increased $14.7 million mainly due to revenue earned for Electronic Health Record Meaningful Use and vendor contract concessions. Significant costs were incurred to purchase and implement the systems necessary to achieve Meaningful Use. Total Revenue increased by $21.0 million or 2.1%.

Total Expenses increased $36.7 million or 3.8%. Salaries, contract labor, and benefits increased by $29.3 million or 6.0% driven by an increase in FTEs in patient care areas to support higher volume as well as an increase in employed providers. Fees increased by $12.0 million mainly as a result of higher purchased services and physician fees. Other expense increased by $6.6 million mainly due to an increase in maintenance contracts for the Electronic Health Record. The above increases were offset by a decrease in depreciation of $14.4 million resulting from a facility being fully depreciated in 2011.

Income from operations of $9.9 million for fiscal 2012 declined by $15.6 million over income from operations in fiscal 2011 of $25.8 million.

Fiscal Year ended June 30, 2013:

Due to volume declines from fiscal 2012, net patient revenue decreased $20.6 million or 2.1%. Other revenue increased $25.1 million mainly due to revenue earned for Electronic Health Record Meaningful Use as compared to approximately $5 million in fiscal 2012. Total Revenue increased by $4.5 million or 0.4%.

Total Expenses increased $13.0 million or 1.3%. Salaries, contract labor, and benefits increased by $3.9 million or 0.8% driven by an decrease in FTEs in patient care areas due to lower volume and a focus on labor management offset by an increase in employed providers. Supply costs decreased by $7.2 million or 4.2% driven by a decrease in volume. Fees increased by $8.0 million mainly as a result of higher purchased services and physician fees. Other expense increased by $4.6 million mainly due to an increase in maintenance contracts for the Electronic Health Record. Depreciation expense increased by $5.9 million due to completion of a new hospital. Interest expense decreased by $2.7 million due to lower interest rates on variable rate debt.

Due to the decline in volume and continued pressure on reimbursement from both governmental and commercial sources, income from operations of $1.6 million for fiscal 2013 declined by $8.3 million over income from operations in fiscal 2012 of $9.9 million.

Fiscal Year ended June 30, 2014:

Net patient revenue decreased $3.8 million or 0.4% under fiscal 2013. Other revenue increased $7.1 million mainly due to premium revenue in the provider sponsored Medicare Advantage health plan. Total Revenue increased by $3.2 million or 0.3%.

Total Expenses decreased $5.5 million or 0.5%. Salaries, contract labor, and benefits increased by $16.4 million or 3.1% driven by an decrease in FTEs in patient care areas due to lower volume and a focus on labor management offset by an increase in employed providers. Fees increased by $9.7 million mainly as a result of higher physician fees. Other expense increased by $9.0 million mainly due to medical costs related to the provider sponsored Medicare Advantage plan. Depreciation expense decreased by $9.5 million due to a change in the estimated useful lives of plant and equipment.

As a result of a focus on cost reduction and operating efficiencies, income from operations of $10.4 million for fiscal 2014 increased by $8.3 million over income from operations in fiscal 2013 of $1.6 million.

Fiscal Year ended June 30, 2015:

Due to an increase in volume, net patient revenue increased $71.5 million or 7.5% over fiscal 2014. Other revenue decreased $0.7 million mainly due to an increase in premium revenue in

the provider sponsored Medicare Advantage health plan offset by a decrease in revenue earned for Electronic Health Record Meaningful Use. Total Revenue increased by $70.8 million or 6.9%.

Total Expenses increased $47.9 million or 4.7%. Salaries, contract labor, and benefits increased by $10.7 million or 2.1% driven by an increase in FTEs in patient care areas due to higher volume. Fees increased by $4.7 million mainly as a result of higher physician fees. Supply costs increased by $12.3 million or 7.5% driven by the increase in volume and increase in cost of pharmaceuticals. Other expense increased by $23.5 million mainly due to medical costs related to the provider sponsored Medicare Advantage plan. Depreciation expense decreased by $2.2 million due a reduction in capital expenditures compared to previous years.

Income from operations of $33.3 million for fiscal 2015 (unaudited) increased by $22.9 million over income from operations in fiscal 2014 of $10.4 million.

Balance Sheet and Ratios:

Fiscal Year ended June 30, 2011:

Total assets increased by approximately $68 million mainly due to an increase in property, plant, and equipment and patient accounts receivable offset by a decline in cash and investments. Total liabilities decreased by almost $18 million mainly due to a decline in long-term debt.

Operating cash flow margins continue to be strong reaching 15.7%. Operating margin for fiscal 2011 was 2.6% with days cash on hand at 253.2. During the period from 2006 to 2009, the Alliance pursued an acquisition growth strategy in its core service area. The Alliance acquired an interest in five hospital facilities and these investments leveraged the balance sheet. Long term debt to capitalization was 64.5% and debt service coverage was 2.6. However, the above average operating cash flow of the Alliance adequately supports the debt load. FTEs per AOB were 4.94 with labor expense as a percentage of net patient revenue at 48.8%.

Fiscal Year ended June 30, 2012:

Total assets decreased by approximately $57 million mainly due to a decline in the market value of investments and capital spending. Total liabilities decreased by approximately $84 million mainly due to the elimination of the call option liability.

Operating margin for fiscal 2012 declined to 1.0%. As a result of the decline in market value of investments, increases in patient receivables, and capital spending, days cash on hand decreased to 214.9. The majority of the decrease in days cash on hand was planned and was a result of funding major construction projects from operating cash flow. Long term debt to capitalization declined to 63.6% and debt service coverage was 2.5. FTEs per AOB were 4.90 with labor expense as a percentage of net patient revenue at 52.3%.

Fiscal Year ended June 30, 2013:

Total assets increased by approximately $98 million mainly due to an increase in market value of investments, an increase in patient receivables and an increase in land and assets held for expansion. Total liabilities increased by approximately $36 million mainly due to an increase in long-term debt offset by a decrease in the fair value of interest rate swaps. The increase in long-term debt was due to borrowings to finance capital expenditures including a new surgery tower project at Johnson City Medical Center.

Operating cash flow margin remained steady however operating margin for fiscal 2013 declined to 0.2%. Days cash on hand increased to 235.4. Long term debt to capitalization declined to 62.3% and debt service coverage declined to 2.3. FTEs per AOB were 4.85 with labor expense as a percentage of net patient revenue at 53.9%.

Fiscal Year ended June 30, 2014:

Total assets increased by approximately $44 million mainly due to an increase in investments and an increase in patient receivables. Capital spending moderated in fiscal 2014 after a period of intense capital spending during the prior six years in which major projects completed during this time included the construction of three replacement hospitals and a new surgery tower. Total liabilities decreased by approximately $16 million mainly due to a decrease in long-term debt.

Operating cash flow margin of approximately 12% remained on par with fiscal 2013. Operating margin for fiscal 2014 increased to 1.0%. Days cash on hand increased to 257.7. Long term debt to capitalization improved to 59.9% and debt service coverage declined to 2.2. FTEs per AOB were 4.49 with labor expense as a percentage of net patient revenue at 52.3%.

Fiscal Year ended June 30, 2015:

Total assets increased by approximately $22 million mainly due to an increase in investments. Total liabilities decreased by approximately $32 million mainly due to a decrease in long-term debt.

Operating margin for fiscal 2014 increased to 3.1%. Days cash on hand increased to 265.3. Long term debt to capitalization improved to 57.1% and debt service coverage improved to 2.3. FTEs per AOB were 4.36 with labor expense as a percentage of net patient revenue at 50.9%.

Attachments:

- Attachment A - Bonds Official Statement for 2011 bonds
- Attachment B - Bonds Official Statement for 2012 bonds
- Attachment C - Bonds Official Statement for 2013 bonds
- Attachment D - Covenant Compliance Certificates for the Last Five Years

- Attachment E - Officer's Certificate accompanying the Independent Auditor's Report for FY10 to FY14
- Attachment F - Audited Financial Statements for 2009 to 2014
- Attachment G - EMMA – Annual Disclosures for 2010 to 2015 and Material Event Disclosures
- Attachment H - Rating Agency Reports

Exhibit 11.4

Attachment A

Mountain States Bonds Official Statement for 2011 Bonds

SUPPLEMENT TO OFFICIAL STATEMENT DATED OCTOBER 14, 2011

$211,800,000
MOUNTAIN STATES HEALTH ALLIANCE

The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds (Mountain States Health Alliance)

Series 2011A
$65,260,000

Series 2011B
$20,000,000

Industrial Development Authority of Smyth County (Virginia) Hospital Revenue Bonds (Mountain States Health Alliance)

Series 2011C
$49,875,000

Series 2011D
$60,705,000

Mountain States Health Alliance Taxable Bonds

Series 2011E
$15,960,000

This Supplement to the Official Statement dated October 14, 2011, has been prepared by Mountain States Health Alliance (the "Alliance") in connection with the issuance and sale by (1) The Health and Educational Facilities Board of the City of Johnson City, Tennessee of its $65,260,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A (the "Series 2011A Bonds"), and its $20,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B (the "Series 2011B Bonds"), (2) the Industrial Development Authority of Smyth County of its $49,875,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the "Series 2011C Bonds"), and its $60,705,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the "Series 2011D Bonds"), and (3) the Alliance of its $15,960,000 Taxable Bonds, Series 2011E (the "Series 2011E Bonds"). The Series 2011A Bonds, the Series 2011B Bonds, the Series 2011C Bonds and the Series 2011E Bonds are referred to collectively as the "Series 2011 Bonds".

This Supplement should be read together with the entire Official Statement. Reference is made to the entire Official Statement for information relevant to the information set forth below as well as other information regarding the Series 2011 Bonds and the Alliance. As with the summaries and explanations in the Official Statement hereby supplemented, summaries and explanations of various documents, or provisions thereof, do not purport to be complete and are qualified by reference to the complete documents. All capitalized terms not defined herein shall have the same meaning as in the Official Statement.

Replacement Information. The following paragraph replaces in its entirety the paragraph with the identical heading in the section "THE SERIES 2011 BONDS" on page 15 of the Official Statement. The sole distinction between the two paragraphs is the addition of the final sentence in the paragraph set forth below.

No Purchase After Event of Default

Anything in the Indentures to the contrary notwithstanding, there shall be no purchases of Series 2011 Bonds pursuant to such Indenture if there shall have occurred and be continuing an Event of Default of which the Trustee has knowledge that immediately requires the acceleration of the Series 2011 Bonds under such Indenture. However, the occurrence of such an Event of Default does not alter the obligation of the Bank under the Letter of Credit, including any obligation of the Bank that occurs in connection with any such acceleration of the Series 2011 Bonds.

Date of Supplement: October 28, 2011

NEW ISSUE - Book-Entry Only **Ratings: (See "RATINGS" herein)**

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described in "TAX MATTERS," interest on the Series 2011 Tax-Exempt Bonds (as defined below) (a) will not be included in gross income for federal income tax purposes, (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations and (c) will not be included in the calculation of adjusted current earnings for purposes of computing the alternative minimum income tax on corporations. Interest on the Series 2011 Tennessee Bonds (as defined below) will be exempt from all state, county and municipal taxation in Tennessee except inheritance, transfer, estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes. The income on the Series 2011 Virginia Bonds (as defined below), including any profit made on the sale thereof, is exempt from all taxation by the Commonwealth of Virginia or any political subdivision thereof. A holder may be subject to other federal tax consequences as described in "TAX MATTERS."

$211,800,000
MOUNTAIN STATES HEALTH ALLIANCE

The Health and Educational Facilities Board of the City of Johnson City, Tennessee
Hospital Revenue Bonds
(Mountain States Health Alliance)

Series 2011A
$65,260,000

Series 2011B
$20,000,000

Industrial Development Authority of Smyth County (Virginia)
Hospital Revenue Bonds
(Mountain States Health Alliance)

Series 2011C
$49,875,000

Series 2011D
$60,705,000

Mountain States Health Alliance
Taxable Bonds

Series 2011E
$15,960,000

Dated: Date of Delivery **Maturity: As shown on inside cover page**

This Official Statement contains information relating to the offering of multiple series of bonds (each, a "Series") by or for the benefit of Mountain States Health Alliance (the "Alliance"), a Tennessee non-profit corporation, and related hospital entities, with all such bonds, both tax exempt and taxable, secured on a parity basis with each other and certain previously issued bonds and bonds that may be issued in the future.

At the request of the Alliance, (1) The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Tennessee Issuer") is issuing its $65,260,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A (the "Series 2011A Bonds"), and its $20,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B (the "Series 2011B Bonds" and, together with the Series 2011A Bonds, the "Series 2011 Tennessee Bonds"), and (2) the Industrial Development Authority of Smyth County (the "Virginia Issuer") is issuing its $49,875,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the "Series 2011C Bonds"), and its $60,705,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the "Series 2011D Bonds" and, together with the Series 2011C Bonds, the "Series 2011 Virginia Bonds"). The Series 2011 Tennessee Bonds and the Series 2011 Virginia Bonds are referred to collectively as the "Series 2011 Tax-Exempt Bonds" and the Tennessee Issuer and the Virginia Issuer are referred to together as the "Issuers." The Series 2011 Tax-Exempt Bonds are limited obligations of the respective Issuer, payable from payments to be made by the Alliance to the Bond Trustee pursuant to separate Loan Agreements between each Issuer and the Alliance and related entities, and pursuant to the Series 2011 Tax-Exempt Obligations, hereinafter defined, which are issued under and secured by the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee, which provides the security for the Series 2011 Tax-Exempt Obligations.

Simultaneously with the issuance of the Series 2011 Tax-Exempt Bonds, the Alliance will issue its own $15,960,000 Taxable Bonds, Series 2011E (the "Series 2011 Taxable Bonds"), which will constitute Obligations issued under and secured by the Master Indenture. The Series 2011 Taxable Bonds and the Series 2011 Tax-Exempt Bonds are referred to collectively as the Series 2011 Bonds. **The Series 2011 Taxable Bonds are being issued directly by the Alliance and not through any governmental authority or other conduit issuer.**

The Series 2011 Bonds will be issued in denominations of $100,000 or any integral multiples of $5,000 in excess thereof and will bear interest at variable rates as described herein from their date of issuance until maturity or any earlier Conversion Date for the Fixed Rate. Each Series of Series 2011 Bonds will be subject to redemption prior to maturity, including optional redemption, mandatory sinking fund redemption and extraordinary optional redemption as described herein. The Series 2011 Bonds will be subject to mandatory tender for purchase prior to maturity under the circumstances described herein.

The timely payment of the principal of and interest on the Series 2011 Bonds and the purchase price of tendered Series 2011 Bonds of each Series will be secured by separate irrevocable, transferable direct-pay letters of credit (each, a "Letter of Credit") issued by the following providers:

Series 2011A	Series 2011B	Series 2011C	Series 2011D	Series 2011E
U.S. Bank National Association	PNC Bank, National Association	U.S. Bank National Association	Mizuho Corporate Bank, Ltd. New York Branch	Mizuho Corporate Bank, Ltd. New York Branch

(each, individually a "Bank" and, collectively, the "Banks"). Each Letter of Credit will entitle the Bond Trustee to draw thereunder amounts equal to the principal amounts of the Series 2011 Bonds outstanding and up to 37 days' interest thereon calculated at a rate of 12% per annum. Each Letter of Credit will expire on October 19, 2014, unless renewed, and each may be replaced by a Substitute Letter of Credit as described herein.

Payment of each Series of Series 2011 Bonds will be secured by a separate Letter of Credit. The Letter of Credit related to one Series of Series 2011 Bonds does not secure payments of principal or purchase price of or interest on any other Series of Series 2011 Bonds.

The Series 2011 Bonds, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Series 2011 Bonds. Purchasers will not receive certificates representing their ownership interest in the Series 2011 Bonds purchased. Interest on the Series 2011 Bonds will accrue from the date of issuance and be payable by the Bond Trustee to DTC for the account of DTC Participants, who are responsible for crediting the accounts of the beneficial owners.

The Series 2011 Tax-Exempt Bonds will be limited obligations of the respective Issuer, payable solely from the sources described in this Official Statement and will not constitute or create any debt, liability or obligation of the State of Tennessee, the Commonwealth of Virginia or any political subdivision or agency thereof or a pledge of the faith and credit of the State of Tennessee, the Commonwealth of Virginia or any political subdivision or agency thereof. Neither the faith and credit nor taxing power of any state or any political subdivision or agency thereof will be pledged to the payment of the Series 2011 Tax-Exempt Bonds.

This cover page contains certain information for quick reference only. It is not a summary of this issue. Investors must read the entire Official Statement to obtain information necessary to make an informed investment decision. For a description of certain risk factors relating to the Series 2011 Bonds, see "CERTAIN RISK FACTORS."

The Series 2011 Tax-Exempt Bonds are offered when, as and if issued, subject to the approving opinion of Bass, Berry & Sims PLC, Nashville and Knoxville, Tennessee, as Bond Counsel, and certain other conditions. As to certain matters of Virginia law, Bond Counsel is relying on the opinion of Hunton & Williams LLP, Richmond, Virginia. In connection with the issuance of the Series 2011 Bonds, certain legal matters will be passed upon by Anderson, Fugate & Givens, Johnson City, Tennessee, as counsel to the Alliance, Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Tennessee Issuer, Gwyn & Tate, Marion, Virginia, as counsel to the Virginia Issuer, Thompson Coburn LLP, St. Louis, Missouri, as counsel to the Banks, and Hunton & Williams LLP, as Underwriters' Counsel. The Public Advisory Corporation serves as financial advisor to the Alliance. It is expected that the Series 2011 Bonds will be issued and available for delivery to DTC in New York, New York, on or about October 19, 2011.

BofA Merrill Lynch
as Underwriter for the Series 2011 Bonds

US Bancorp
as Co-Manager for the Series 2011A and 2011C Bonds

Dated: October 14, 2011

INFORMATION REGARDING MATURITIES, INITIAL RATE PERIODS AND REMARKETING AGENTS

The Health and Educational Facilities Board of the City of Johnson City, Tennessee
Hospital Revenue Bonds
(Mountain States Health Alliance),

$65,260,000
Series 2011A
Initial Rate Period: Weekly
Due: July 1, 2033
Cusip: 478271 JS9
Remarketing Agent:
BofA Merrill Lynch

$20,000,000
Series 2011B
Initial Rate Period: Weekly
Due: July 1, 2033
Cusip: 478271 JT7
Remarketing Agent:
BofA Merrill Lynch

Industrial Development Authority of Smyth County
Hospital Revenue Bonds
(Mountain States Health Alliance),

$49,875,000
Series 2011C
Initial Rate Period: Weekly
Due: July 1, 2031
Cusip: 832870 AT6
Remarketing Agent:
U.S. Bancorp Investments, Inc.
and
U.S. Bank Municipal Securities Group,
a division of
U.S. Bank National Association

$60,705,000
Series 2011D
Initial Rate Period: Weekly
Due: July 1, 2031
Cusip: 832870 AU3
Remarketing Agent:
BofA Merrill Lynch

$15,960,000
Mountain States Health Alliance
Taxable Bonds
Series 2011E
Interest Rate Period: Weekly
Due: July 1, 2026
Cusip: 62427T AA9
Remarketing Agent:
BofA Merrill Lynch

No dealer, salesperson, or other person has been authorized to give any information or to make any representation, other than the information contained in this Official Statement, in connection with the offering of the Series 2011 Bonds, and, if given or made, such information or representation must not be relied upon as having been authorized by the Issuers, the Alliance or the Underwriters. The information in this Official Statement is subject to change without notice, and neither the delivery of this Official Statement nor any sale hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the Issuers, the Alliance or others since the date hereof. This Official Statement does not constitute an offer or solicitation in any jurisdiction in which such offer or solicitation is not authorized, or in which any person making such offer or solicitation is not qualified to do so, or to any person to whom it is unlawful to make such offer or solicitation. The information set forth herein has been obtained from the Issuers, the Alliance and other sources that are believed to be reliable, but it is not guaranteed as to accuracy or completeness by the Underwriters.

THE PRICES AT WHICH THE SERIES 2011 BONDS ARE OFFERED TO THE PUBLIC BY THE UNDERWRITERS MAY VARY FROM THE INITIAL PUBLIC OFFERING PRICES APPEARING ON THE FOREGOING PAGE. IN ADDITION, THE UNDERWRITERS MAY ALLOW CONCESSIONS OR DISCOUNTS TO DEALERS AND OTHER FROM THE PRICES AT WHICH THE SERIES 2011 BONDS ARE OFFERED TO THE PUBLIC. IN CONNECTION WITH THE OFFERING OF THE SERIES 2011 BONDS, THE UNDERWRITERS MAY EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICE OF THE SERIES 2011 BONDS AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

THE SERIES 2011 BONDS WILL NOT BE REGISTERED BY THE ISSUERS OR THE ALLIANCE UNDER THE SECURITIES ACT OF 1933, AS AMENDED, OR ANY STATE SECURITIES LAW AND WILL NOT BE LISTED ON ANY STOCK OR OTHER SECURITIES EXCHANGE. NEITHER THE SECURITIES AND EXCHANGE COMMISSION NOR ANY OTHER FEDERAL, STATE, MUNICIPAL, OR OTHER GOVERNMENTAL ENTITY OR AGENCY SHALL HAVE PASSED UPON THE ACCURACY OR ADEQUACY OF THIS OFFICIAL STATEMENT.

IN MAKING ANY INVESTMENT DECISION, INVESTORS MUST RELY ON THEIR OWN EXAMINATION OF THE TERMS OF THE OFFERING, INCLUDING THE MERITS AND RISKS INVOLVED. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY ANY FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

THIS OFFICIAL STATEMENT CONTAINS FORWARD-LOOKING STATEMENTS THAT ARE SUBJECT TO A NUMBER OF RISKS AND UNCERTAINTIES, INCLUDING THOSE DESCRIBED IN "CERTAIN RISK FACTORS," HEREIN, MANY OF WHICH ARE BEYOND THE ISSUERS AND THE ALLIANCE'S CONTROL. FORWARD-LOOKING STATEMENTS ARE TYPICALLY IDENTIFIED BY WORDS SUCH AS "BELIEVE," "EXPECT," "ANTICIPATE," "INTEND," "ESTIMATE" AND SIMILAR EXPRESSIONS. ACTUAL RESULTS COULD DIFFER MATERIALLY FROM THOSE CONTEMPLATED BY THESE FORWARD-LOOKING STATEMENTS AS A RESULT OF FACTORS ("CAUTIONARY STATEMENTS") SUCH AS THOSE DESCRIBED IN "CERTAIN RISK FACTORS" HEREIN. IN LIGHT OF THESE RISKS AND UNCERTAINTIES, THERE CAN BE NO ASSURANCE THAT THE RESULTS AND EVENTS CONTEMPLATED BY THE FORWARD-LOOKING INFORMATION CONTAINED IN THIS OFFICIAL STATEMENT WILL IN FACT TRANSPIRE. YOU ARE CAUTIONED NOT TO PLACE UNDUE RELIANCE ON THESE FORWARD-LOOKING STATEMENTS. NEITHER THE ISSUERS NOR THE ALLIANCE UNDERTAKE ANY OBLIGATION TO UPDATE OR REVISE ANY FORWARD-LOOKING STATEMENTS. ALL SUBSEQUENT WRITTEN OR ORAL FORWARD-LOOKING STATEMENTS ATTRIBUTABLE TO THE ISSUERS AND THE ALLIANCE OR PERSONS ACTING ON THEIR BEHALF ARE EXPRESSLY QUALIFIED IN THEIR ENTIRETY BY THE CAUTIONARY STATEMENTS.

Other than with respect to information concerning each Bank and its respective Letter of Credit contained under the headings "THE LETTERS OF CREDIT - Terms of the Letters of Credit" and "THE BANKS" and in Appendix G, none of the information in this Official Statement has been supplied or verified by the Banks, and the Banks do not make any warranty, express or implied, as to (i) the accuracy or completeness of such information, (ii) the validity of the Bonds, or (iii) the tax status of interest on the Bonds.

The Remarketing Agent is Paid by the Alliance. The Remarketing Agent's responsibilities include determining the interest rate from time to time and remarketing Series 2011 Bonds that are optionally or mandatorily tendered by the owners thereof, all as further described in this Official Statement. The Remarketing Agent is appointed by the Alliance and is paid by the Alliance for its services. As a result, the interests of the Remarketing Agent may differ from those of existing holders and potential purchasers of Series 2011 Bonds.

The Remarketing Agent Routinely Purchases Series 2011 Bonds for its Own Account. The Remarketing Agent is permitted, but not obligated, to purchase tendered Series 2011 Bonds for its own account. The Remarketing Agent, in its sole discretion, routinely acquires tendered Series 2011 Bonds for its own inventory in order to achieve a successful remarketing of the Series 2011 Bonds (i.e., because there otherwise are not enough buyers to purchase the Series 2011 Bonds) or for other reasons. However, the Remarketing Agent is not obligated to purchase Series 2011 Bonds, and may cease doing so at any time without notice. The Remarketing Agent may also make a market in the Series 2011 Bonds by routinely purchasing and selling Series 2011 Bonds other than in connection with an optional or mandatory tender and remarketing. Such purchases and sales may be at or below par. However, the Remarketing Agent is not required to make a market in the Series 2011 Bonds. The Remarketing Agent may also sell any Series 2011 Bonds it has purchased to one or more affiliated investment vehicles for collective ownership or enter into derivative arrangements with affiliates or others in order to reduce its exposure to the Series 2011 Bonds. The purchase of Series 2011 Bonds by the Remarketing Agent may create the appearance that there is greater third party demand for the Series 2011 Bonds in the market than is actually the case. The practices described above also may reduce the supply of Series 2011 Bonds that may be tendered in a remarketing.

Series 2011 Bonds May Be Offered at Different Prices on any Date. The Remarketing Agent is required to determine on the Adjustment Date the applicable rate of interest that, in its judgment, is the lowest rate that would permit the sale of the Series 2011 Bonds at par plus accrued interest, if any, on the Adjustment Date. The interest rate will reflect, among other factors, the level of market demand for the Series 2011 Bonds (including whether the Remarketing Agent is willing to purchase Series 2011 Bonds for its own account). There may or may not be Series 2011 Bonds tendered and remarketed on an Adjustment Date, the Remarketing Agent may or may not be able to remarket any Series 2011 Bonds tendered for purchase on such date at par and the Remarketing Agent may sell Series 2011 Bonds at varying prices to different investors on such date or any other date. The Remarketing Agent is not obligated to advise purchasers in a remarketing if it does not have third party buyers for all of the Series 2011 Bonds at the remarketing price. In the event the Remarketing Agent owns any Series 2011 Bonds for its own account, the Remarketing Agent may, in its sole discretion in a secondary market transaction outside the tender process, offer the Series 2011 Bonds on any date, including the Adjustment Date, at a discount to par to some investors.

The Ability To Sell the Series 2011 Bonds other than through Tender Process May Be Limited. While the Remarketing Agent may buy and sell Series 2011 Bonds, it is not obligated to do so and may cease doing so at any time without notice. Thus, investors who purchase the Series 2011 Bonds, whether in a remarketing or otherwise, should not assume that they will be able to sell their Series 2011 Bonds other than by tendering the Series 2011 Bonds in accordance with the tender process. The Letter of Credit is not available to purchase Series 2011 Bonds other than those tendered in accordance with a sale of Series 2011 Bonds by the bondholder to the Remarketing Agent. The Letter of Credit will only be drawn when such Series 2011 Bonds have been properly tendered in accordance with the terms of the transaction.

Remarketing Agent May Be Removed, Resign or Cease Remarketing the Series 2011 Bonds Without a Successor Being Named. Under certain circumstances the Remarketing Agent may be removed or have the ability to resign or cease its remarketing efforts, without a successor having been named, subject to the terms of the Remarketing Agreement.

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OFFICIAL STATEMENT

INTRODUCTION

This Official Statement, including its cover page and appendices, provides information in connection with the issuance and sale of multiple series of bonds by or for the benefit of Mountain States Health Alliance (the "Alliance"), a Tennessee non-profit corporation, and related entities, with all such bonds, both tax exempt and taxable, secured on a parity basis with each other and certain previously issued bonds and bonds that may be issued in the future. See below "Sources of Payment and Security for the Series 2011 Bonds."

The Series 2011 Tax Exempt Bonds

At the request of the Alliance, bonds will be issued for the benefit of the Alliance by (1) The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Tennessee Issuer"), and (2) the Industrial Development Authority of Smyth County (the "Virginia Issuer").

The Tennessee Issuer is issuing the following series of bonds (collectively, the "Series 2011 Tennessee Bonds"):

$65,260,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A (the "Series 2011A Bonds"), and

$20,000,000 the Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B (the "Series 2011B Bonds").

The Virginia Issuer is issuing the following series of bonds (collectively, the "Series 2011 Virginia Bonds"):

$49,875,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the "Series 2011C Bonds"), and

$60,705,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the "Series 2011D Bonds").

The Series 2011 Tennessee Bonds and the Series 2011 Virginia Bonds are referred to collectively as the "Series 2011 Tax-Exempt Bonds," and the Tennessee Issuer and the Virginia Issuer are referred to collectively as the "Issuers." Capitalized terms used herein and not otherwise defined have the meanings given thereto (1) in the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"), (2) in the case of the Series 2011 Tax-Exempt Bonds, in separate Bond Trust Indentures, each dated as of October 1, 2011 (the "Tennessee Indenture" and the "Virginia Indenture" and together, the "Issuer Bond Indentures"), between the respective Issuers and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee"), and (3) in the case of the Series 2011 Taxable Bonds, in the Thirtieth Supplemental Master Trust Indenture dated as of October 1, 2011 (the "Thirtieth Supplement"), between the Alliance and the Master Trustee.

The terms "Indenture" and "Indentures" are used herein (a) to refer to the Issuer Bond Indentures when applicable to the Series 2011 Tax-Exempt Bonds and (b) to refer to the Thirtieth Supplement when applicable to the Series 2011 Taxable Bonds. Likewise, the term "Trustee" is used herein (a) to refer to the Bond Trustee when applicable to the Series 2011 Tax-Exempt Bonds and (b) to refer to the Master Trustee when applicable to the Series 2011 Taxable Bonds.

The Series 2011 Taxable Bonds

The Series 2011 Taxable Bonds will be issued in the amount of $15,960,000 by the Alliance pursuant to the Thirtieth Supplement. The Series 2011 Taxable Bonds are being issued directly by the Alliance and not through any governmental authority or other conduit issuer.

The Alliance

The Mountain States Health Alliance (the "Alliance") is a Tennessee nonprofit corporation that is an "exempt organization" under Section 501(c)(3) of the Internal Revenue Code of 1986 (the "Code"). The Alliance provides an integrated, comprehensive continuum of care to people in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. The Alliance currently operates 13 hospital facilities containing a total of 1,749 licensed beds, and serves a population of over 1,000,000 in 29 counties and two independent cities in the States of Tennessee, Virginia, Kentucky and North Carolina. Its integrated health care delivery system also includes 23 primary/preventive care centers and 12 outpatient care sites. **For additional information regarding the Alliance, see Appendix A.**

The Obligated Issuers

The Alliance, Blue Ridge Medical Management Corporation ("Blue Ridge"), Norton Community Hospital ("Norton") and Smyth County Community Hospital ("Smyth") are each an Obligated Issuer as such term is used in the Master Indenture (hereinafter defined). Only the Obligated Issuers are obligated to make payments on the Series 2011 Bonds. See Appendix A - "HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates," and "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

The Banks

The timely payment of the principal of and interest on the Series 2011 Bonds and the purchase price thereof will be secured by irrevocable transferable direct-pay letters of credit issued by (1) in the case of the Series 2011A Bonds and the Series 2011C Bonds, U.S. Bank National Association, (2) in the case of the Series 2011B Bonds, PNC Bank, National Association, and (3) in the case of the Series 2011D Bonds and the Series 2011 Taxable Bonds, Mizuho Corporate Bank, Ltd. See Appendix G.

The Remarketing Agents

Merrill Lynch, Pierce, Fenner and Smith Incorporated will serve as the Remarketing Agent for the Series 2011 Tennessee Bonds, the Series 2011D Bonds and the Series 2011 Taxable Bonds. U.S. Bancorp Investments, Inc. and U.S. Bank Municipal Securities Group, a division of U.S. Bank National Association, will serve as the Remarketing Agent for the Series 2011C Bonds.

Plan of Finance

The proceeds of the Series 2011 Tax-Exempt Bonds are being loaned to the Alliance pursuant to separate Loan Agreements, each dated as of October 1, 2011 (respectively, the "Tennessee Loan Agreement" and the "Virginia Loan Agreement" and, together, the "Loan Agreements"), between each Issuer and the Alliance and related entities. The proceeds of the Series 2011 Tax-Exempt Bonds will be used by the Alliance and related entities (1) to refinance outstanding indebtedness (2) to finance capital improvements and equipment acquisitions at facilities owned by the Alliance and its affiliates and (3) to pay certain expenses incurred in connection with the issuance of the Series 2011 Tax-Exempt Bonds. The proceeds from the sale of the Series 2011 Taxable Bonds will be used to finance capital improvements and equipment acquisitions at facilities owned by Smyth and Blue Ridge Medical Management Corporation, an affiliate of the Alliance. See "PLAN OF FINANCE."

Book-Entry Registration

The Series 2011 Bonds initially will be issued in the form of one registered bond in the aggregate principal amount of each maturity of each Series and will be registered in the name of Cede & Co., as nominee for The

Depository Trust Company, New York, New York ("DTC"). DTC will maintain a book-entry system for recording ownership interest in the Series 2011 Bonds. Purchasers will not receive certificates representing their ownership interest in the Series 2011 Bonds purchased. Principal of, any redemption price for, and interest on the Series 2011 Bonds will be payable by the Trustee to DTC for the account of DTC Participants (as defined herein), who are responsible for crediting the accounts of the beneficial owners. See Appendix H - "BOOK-ENTRY ONLY SYSTEM."

Sources of Payment and Security for the Series 2011 Tax-Exempt Bonds

The Series 2011 Tax-Exempt Bonds shall not constitute a debt or obligation of the State of Tennessee or the Commonwealth of Virginia or any political subdivision or agency thereof or a pledge of the faith and credit of any state or any political subdivision or agency of any state, including the Tennessee Issuer and the Virginia Issuer. The Series 2011 Tennessee Bonds are special, limited obligations of the Tennessee Issuer and the Series 2011 Virginia Bonds are limited obligations of the Virginia Issuer, each payable from the respective Trust Estates as described in "THE SERIES 2011 BONDS - General" and "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2011 BONDS - Trust Estate."

To evidence the Alliance's repayment obligations in connection with the Series 2011 Tax-Exempt Bonds, the Alliance will issue its $65,260,000 Mountain States Health Alliance Note (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) Series 2011A (the "Series 2011A Obligation"), its $20,000,000 Mountain States Health Alliance Note (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) Series 2011B (the "Series 2011B Obligation"), its $49,875,000 Mountain States Health Alliance Note (Industrial Development Authority of Smyth County) Series 2011C (the "Series 2011C Obligation"), and its $60,705,000 Mountain States Health Alliance Note (Industrial Development Authority of Smyth County) Series 2011D (the "Series 2011D Obligation" and, together with the Series 2011A Obligation, the Series 2011B Obligation and the Series 2011C Obligation, the "Series 2011 Tax-Exempt Obligations"), all pursuant to the Master Indenture.

The Series 2011 Taxable Bonds will also be issued pursuant to, and are secured by the Master Indenture and will constitute Obligations thereunder. The Series 2011 Tax-Exempt Obligations and the Series 2011 Taxable Bonds are referred to collectively as the "Series 2011 Obligations."

In the Master Indenture, the Alliance and the other Obligated Issuers have covenanted, and any future Obligated Issuer would be required to covenant, to operate its facilities in such a manner and to charge such fees and rates as will be sufficient to provide funds (together with other available amounts) to pay debt service on its outstanding indebtedness, to pay certain other expenses and indebtedness of the Alliance and all future Obligated Issuers, and to maintain a coverage ratio of Income Available for Debt Service to Maximum Annual Debt Service equal to at least 1.30:1. For a description of such covenants, including exceptions thereto, see "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2011 BONDS" and Appendix D - "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE."

Certain existing bonds of the Tennessee Issuer, the Virginia Issuer and other issuers, as well as bonds of the Alliance, previously have been issued and are secured by Master Obligations issued by the Alliance under the Master Indenture ("Master Obligations") and therefore are secured on a parity with the Series 2011 Bonds. The reimbursement obligations of the Alliance with respect to the Letters of Credit will be secured under the Master Indenture. The Alliance and any future Obligated Issuer have the right, subject to specified conditions, to incur additional indebtedness on a parity with the Series 2011 Obligations and the Series 2011 Bonds.

No Debt Service Reserve Fund

The Series 2011 Bonds are not secured by any Debt Service Reserve Fund.

Tax Matters

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described under "TAX MATTERS," interest on the Series 2011 Tax-Exempt Bonds (a) will not be included in gross

income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations; however, such interest on the Series 2011 Tax-Exempt Bonds is taken into account in determining a corporation's alternative minimum income tax. Holders of Series 2011 Tax-Exempt Bonds may be subject to other federal tax consequences, as described herein under "TAX MATTERS." Interest on the Series 2011 Taxable Bonds will be included in gross income for federal income tax purposes.

In the opinion of Bond Counsel, interest on the Series 2011 Tennessee Bonds will be exempt from all state, county, and municipal taxation in the State of Tennessee except inheritance, gift, and estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes, and income on the Series 2011 Virginia Bonds, including any profit made on the sale thereof, is exempt from all taxation by the Commonwealth of Virginia or any political subdivision thereof. In giving its opinion, Bond Counsel is relying on the opinion of Hunton & Williams LLP as to certain matters of Virginia law, including Virginia tax law.

Continuing Disclosure

To permit compliance with Rule 15c2-12 promulgated under the Securities Exchange Act of 1934 ("Rule 15c2-12"), the Alliance will execute a Continuing Disclosure Agreement in connection with the issuance of the Series 2011 Bonds in which it will agree for the benefit of the holders of the Series 2011 Bonds to provide certain annual financial information and operating data and certain quarterly financial data as to the Alliance and any future Obligated Issuer under the Master Indenture, and to provide notice of certain enumerated events, if material. See "CONTINUING DISCLOSURE AGREEMENT" for a more complete description of the Continuing Disclosure Agreement and the Alliance's performance under previous continuing disclosure agreements.

Professionals Involved in the Offering

Bass, Berry & Sims PLC will act as Bond Counsel in connection with the issuance of the Series 2011 Bonds. As to certain matters of Virginia law, Bond Counsel is relying on the opinion of Hunton & Williams LLP. In connection with the issuance of the Series 2011 Bonds, certain legal matters will be passed upon by Anderson, Fugate & Givens, Johnson City, Tennessee, as counsel to the Alliance, Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Tennessee Issuer, Gwyn & Tate, Marion, Virginia, as counsel to the Virginia Issuer, Thompson Coburn LLP, St. Louis, Missouri, as counsel to the Banks, and Hunton & Williams LLP, as Underwriters' Counsel. The Alliance's consolidated financial statements for the fiscal years ended June 30, 2010 and 2009, included in Appendix B hereto, have been audited by Pershing Yoakley & Associates, P.C.

Relationships of the Parties

The Alliance has entered into interest rate exchange agreements, or swap agreements, with Bank of America, which is an affiliate of Bank of America Merrill Lynch, underwriter for the Series 2011 Bonds.

Acceleration

Subject to certain conditions, the Series 2011 Bonds are subject to acceleration of the maturity date upon the happening of an Event of Default under the Indentures. See "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE INDENTURES" in Appendix D.

Bondholders' Risks

Payment of the Series 2011 Bonds is dependent on the ability of the Alliance and the other Obligated Issuers to make payments under the Loan Agreements and the Master Indenture. The Alliance's ability to make such payments may be adversely affected by many risk factors. There may also be legal and practical limitations on the enforcement of remedies and amounts that may be realized upon enforcement of remedies available to the Trustee and owners of the Series 2011 Bonds. See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2011 BONDS" and "CERTAIN RISK FACTORS" herein and "SOURCES OF REVENUE" in Appendix A.

Legal Document Summaries and Definitions

Certain provisions of the Master Indenture, the Indentures and the Loan Agreements are summarized in Appendix D hereto. Other definitions of certain terms used in this Official Statement are also set forth in Appendix D hereto.

Other Information

This Official Statement speaks only as of its date, and the information contained herein is subject to change.

The quotations from, and summaries and explanations of, the statutes, regulations and documents referenced herein do not purport to be complete and reference is made to those statutes, regulations and documents for full and complete statements of their provisions. Copies, in reasonable quantity, of such documents may be obtained during the offering period, upon request to the Alliance and upon payment to the Alliance of a charge for copying, mailing and handling, at 400 North State of Franklin Road, Johnson City, TN 37604-6094, Attn: Legal Department.

Purchasers of the Series 2011 Bonds should note the use of forward-looking information and the covenants related thereto.

Any statements in this Official Statement involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact. This Official Statement is not to be construed as a contract or agreement between the Board or the Alliance and the purchasers or holders of any of the Series 2011 Bonds.

This introduction is not a summary of this Official Statement. It is only a summary description of and guide to, and is qualified by, more complete and detailed information contained in the entire Official Statement, including the cover page and appendices hereto, and the documents summarized or described herein. A full review should be made of the entire Official Statement. The offering of Series 2011 Bonds to potential investors is made only by means of the entire Official Statement.

THE ISSUERS

The Tennessee Issuer

The Tennessee Issuer is a public nonprofit corporation organized under the laws of the State of Tennessee. The Tennessee Issuer was incorporated on May 3, 1973, by the Board of Commissioners of the City of Johnson City, Tennessee, pursuant to the laws now codified under Tennessee Code Annotated Section 48-101-301, *et seq.* (the "Tennessee Act"). The Tennessee Act authorizes the Issuer, among other things, to issue its bonds, to acquire, improve, maintain, extend, equip and furnish hospital facilities either within or without the corporate limits of the City of Johnson City, and in certain other jurisdictions in Tennessee, to mortgage its projects, to pledge the revenues and receipt therefrom, and to sell, exchange, donate and convey any or all of its properties. The Tennessee Issuer has no taxing power.

The Virginia Issuer

The Virginia Issuer was created pursuant to the Virginia Industrial Development and Revenue Bond Act, Title 15.2, Chapter 49 of the Code of Virginia of 1950, as amended (the "Virginia Act"), by ordinance adopted by the Board of Supervisors of Smyth County, Virginia. The Virginia Issuer is a political subdivision of the Commonwealth of Virginia governed by a Board of Directors appointed by the Board of Supervisors of Smyth County, Virginia. Under the Virginia Act, the Virginia Issuer is empowered, among other things, to make loans for the purpose of financing or refinancing medical facilities, and to finance the same by the issuance of its revenue bonds and to refund bonds previously issued by it. The Virginia Issuer has no taxing power.

THE ALLIANCE

The Alliance is a Tennessee nonprofit corporation recognized by the Internal Revenue Service as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 (the "Code"). Today, the Alliance directly and through related entities provides an integrated, comprehensive continuum of care to people in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. The Alliance was initially incorporated as Memorial Hospital on April 12, 1945, as a non-sectarian, general welfare, not-for-profit corporation. In connection with the relocation of its operations, it changed its name to Johnson City Medical Center Hospital, Inc. in 1983. In 1998, Johnson City Medical Center Hospital, Inc. assumed operating responsibility for five hospitals and related assets, which it acquired from Columbia/HCA. In recognition of its expanded facilities and scope of services resulting from the 1998 acquisition, Johnson City Medical Center Hospital, Inc. changed its name to Mountain States Health Alliance.

The Alliance currently operates 13 hospital facilities: Johnson City Medical Center (including The Children's Hospital at Johnson City Medical Center), The James H. & Cecile C. Quillen Rehabilitation Hospital, Indian Path Medical Center, Sycamore Shoals Hospital, Johnson County Community Hospital, Woodridge Hospital, Smyth County Community Hospital, Norton Community Hospital, Dickenson Community Hospital, Russell County Medical Center and Johnston Memorial Hospital. The Alliance now has a total of 1,749 licensed beds serving a population of over 1,000,000 in 29 counties in the States of Tennessee, Virginia, Kentucky and North Carolina. In addition to its hospitals, the Alliance's integrated health care delivery system includes 23 primary/preventive care centers and 12 outpatient care sites. The Alliance's medical facilities provide a full spectrum of general and specialty medical services, including rehabilitative services for individuals with brain injuries, strokes and spinal cord injuries, in-patient psychiatric services and centers for health focusing on cardiovascular health, pulmonary medicine, women's health and cancer therapy, among other services. The Alliance also serves as a clinical training facility for medical students, residents, and nursing students from the East Tennessee State University's James H. Quillen College of Medicine and the School of Public and Allied Health. **For additional information regarding the Alliance, see Appendix A.**

The Alliance, Blue Ridge Medical Management Corporation ("Blue Ridge"), Norton Community Hospital ("Norton") and Smyth County Community Hospital ("Smyth") are each an Obligated Issuer as such term is used in the Master Indenture. Blue Ridge is a wholly-owned, for-profit subsidiary of the Alliance. Norton is a Virginia non-stock corporation in which the Alliance owns a 50.1% interest. Smyth is a Virginia non-stock corporation in which the Alliance owns an 80% interest. See Appendix A - "HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates."

The Alliance also operates the Virginia hospital facilities in Dickenson County and Washington County through ownership of a majority interest in the membership of the corporations owning such facilities. None of such corporations are an Obligated Issuer or otherwise are responsible for repayment of amounts due from the Alliance with respect to the Series 2011 Bonds, and none of the assets of such corporations are pledged as security for the Alliance's payment obligations.

Only the Obligated Issuers are obligated to pay the Series 2011 Bonds. The audited and unaudited financial statements of the Alliance included as Appendices B and C reflect the assets, liabilities, revenues and expenses of related organizations that are not Obligated Issuers. See Appendix A − "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

THE SERIES 2011 BONDS

Set forth below is a summary of certain provisions of the Series 2011 Bonds. General information describing the Series 2011 Bonds appears elsewhere in this Official Statement. That information should be read in conjunction with this summary, which is qualified in its entirety by reference to the Indentures, and the forms of the Series 2011 Bonds. See "SUMMARY OF THE FINANCING DOCUMENTS" in Appendix D hereto.

General

The Series 2011 Bonds shall be initially issued as fully registered bonds without coupons in denominations of $100,000 or any integral multiple of $5,000 in excess thereof. The Series 2011 Bonds will mature, subject to prior redemption as described herein, on July 1, in the years noted below, and will bear interest payable on the first Business Day of each month so long as the Series 2011 Bonds bear interest at the Weekly Rate, as defined below. In the event the interest on any Series of Series 2011 Bonds is converted to the Medium-Term Rate or the Fixed Rate, as defined below, interest will be payable semiannually on January 1 and July 1 of each year (each such date referred to herein as an "Interest Payment Date"). The Weekly Rate for Series 2011 Bonds of different Series may be different rates at any time.

The Series 2011 Tennessee Bonds will mature on July 1, 2033. The Series 2011 Virginia Bonds will mature on July 1, 2031. The Series 2011 Taxable Bonds will mature on July 1, 2026.

Interest on the Series 2011 Bonds shall be computed from the Interest Payment Date to which interest on the Series 2011 Bonds has been paid or duly provided for next preceding the date of authentication thereof, unless (a) such date of authentication shall be prior to the first Interest Payment Date, in which case interest shall be computed from the Closing Date, or (b) such date of authentication shall be an Interest Payment Date to which interest on the Series 2011 Bonds has been paid or duly provided for, in which case interest shall be computed from such Interest Payment Date, or (c) such date of authentication shall be after any Record Date and before the next succeeding Interest Payment Date, in which case interest shall be computed from the next succeeding Interest Payment Date.

The principal and premium, if any, of the Series 2011 Bonds, and the purchase price for any Series 2011 Bonds shall be payable at the office of the Trustee in East Syracuse, New York, upon surrender of the Series 2011 Bonds at such office. Interest on the Series 2011 Bonds (other than Defaulted Interest) shall be payable by check drawn upon the Trustee and paid to the Persons in whose names the Series 2011 Bonds are registered on the Bond Register as of the close of business on the Record Date next preceding the relevant Interest Payment Date, provided that during Weekly Rate Periods, on written request to the Trustee by any Person who is the registered owner of Series 2011 Bonds of a Series in a principal amount of $1,000,000 or more received by the Trustee on or before 15 days prior to such Record Date (which instructions shall remain in effect until revoked by subsequent written instructions), interest on such Series 2011 Bonds shall be payable by wire transfer of immediately available funds to an account at a bank located in the continental United States specified by the person in whose name such Series 2011 Bonds are registered. Any interest on any Series 2011 Bond which is payable but which is not punctually paid or duly provided for ("Defaulted Interest") shall cease being payable to the person in whose name such Series 2011 Bond is registered on the Record Date and instead shall be payable to the person in whose name such Series 2011 Bond is registered at close of business on a Special Record Date selected by the Trustee and which shall be at least 10 days but not more than 30 days before the date selected by the Trustee for payment of such Defaulted Interest. The Trustee shall give Notice by Mail of the Special Record Date and date for payment of Defaulted Interest at least 10 days before the Special Record Date.

THE SERIES 2011 TENNESSEE BONDS ARE, AND ARE TO BE, EQUALLY AND RATABLY SECURED, TO THE EXTENT PROVIDED IN THE APPLICABLE TENNESSEE BOND INDENTURE, SOLELY BY A PLEDGE OF THE REVENUES AND OTHER FUNDS PLEDGED UNDER SUCH TENNESSEE BOND INDENTURE. THE SERIES 2011 TENNESSEE BONDS, TOGETHER WITH PREMIUM, IF ANY, AND THE INTEREST THEREON, ARE SPECIAL AND LIMITED OBLIGATIONS OF THE TENNESSEE ISSUER. THE SERIES 2011 TENNESSEE BONDS AND THE INTEREST THEREON SHALL NOT BE DEEMED TO CONSTITUTE A DEBT OR A PLEDGE OF THE FAITH AND CREDIT OF THE STATE OF TENNESSEE OR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE CITY OF JOHNSON CITY, TENNESSEE. THE CITY OF JOHNSON CITY, TENNESSEE, SHALL NOT IN ANY EVENT BE LIABLE FOR THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE SERIES 2011 TENNESSEE BONDS, OR FOR THE PERFORMANCE OF ANY PLEDGE, MORTGAGE, OBLIGATION OR AGREEMENT OF ANY KIND WHATSOEVER THEREIN OR INDEBTEDNESS BY THE TENNESSEE ISSUER, AND NEITHER THE SERIES 2011 TENNESSEE BONDS NOR ANY OF THE TENNESSEE ISSUERS AGREEMENTS OR OBLIGATIONS DESCRIBED IN THE SERIES 2011 TENNESSEE BONDS OR OTHERWISE SHALL BE CONSTRUED TO CONSTITUTE AN INDEBTEDNESS OF THE CITY OF

JOHNSON CITY, TENNESSEE, WITHIN THE MEANING OF ANY CONSTITUTIONAL OR STATUTORY PROVISIONS WHATSOEVER. THE TENNESSEE ISSUER HAS NO TAXING AUTHORITY.

THE SERIES 2011 VIRGINIA BONDS AND THE PREMIUM, IF ANY, AND THE INTEREST THEREON SHALL NOT BE DEEMED TO CONSTITUTE A DEBT OR A PLEDGE OF THE FAITH AND CREDIT OF THE COMMONWEALTH OF VIRGINIA, OR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE VIRGINIA ISSUER OR SMYTH COUNTY, VIRGINIA. NEITHER THE COMMONWEALTH OF VIRGINIA, NOR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE VIRGINIA ISSUER OR SMYTH COUNTY, VIRGINIA, SHALL BE OBLIGATED TO PAY PRINCIPAL OF OR PREMIUM, IF ANY, OR INTEREST ON THE SERIES 2011 VIRGINIA BONDS OR OTHER COSTS INCIDENT THERETO, AND NEITHER THE FAITH AND CREDIT NOR THE TAXING POWER OF THE COMMONWEALTH OF VIRGINIA OR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE VIRGINIA ISSUER IS PLEDGED TO THE PAYMENT OF PRINCIPAL OF THE SERIES 2011 VIRGINIA BONDS OR INTEREST THEREON OR OTHER COSTS INCIDENT THERETO. THE VIRGINIA ISSUER HAS NO TAXING POWER.

Interest Rate on the Series 2011 Bonds

The Remarketing Agent shall determine the interest rate on the Series 2011 Bonds of a Series for each Weekly Rate Period, as defined in the next sentence. "Weekly Rate Periods" shall mean any period from and commencing on any Wednesday (or in certain circumstances on a Proposed Conversion Date) and ending on the earliest of (a) the next succeeding Tuesday (including such Tuesday), (b) the Conversion Date to the Fixed Rate, (c) the Interest Payment Date on which a Medium-Term Rate Period begins or (d) maturity of the Series 2011 Bonds of that Series. The interest rate on the Series 2011 Bonds of a series shall be determined by the Remarketing Agent for each Weekly Rate Period as the rate equal to the lowest rate which, having due regard for general financial conditions and such other special conditions as in the judgment of the Remarketing Agent may have a bearing on the rate, would produce as nearly as possible a par bid for the Series 2011 Bonds of a series (without regard to accrued interest) in the secondary market on the first day of such Weekly Rate Period. The rate for any Weekly Rate Period shall be determined prior to 10:00 a.m., New York City time on the first day for any Weekly Rate Period. The first day of any Weekly Rate Period is referred to herein as an "Adjustment Date." On the Adjustment Date, the Remarketing Agent shall notify the Trustee no later than 10:00 a.m., New York City time of the rate applicable for such Weekly Rate Period. Any time after 10:00 a.m., New York City time on the Adjustment Date, any Bondholder may contact the Remarketing Agent to obtain such rate.

In the event the Remarketing Agent fails to determine the rate for any Weekly Rate Period, the rate of interest borne by (1) the Series 2011 Tax-Exempt Bonds for such Weekly Rate Period shall be the SIFMA Municipal Swap Index and (2) the Series 2011 Taxable Bonds for such Weekly Rate Period shall be the one-month LIBOR rate.

In no event shall the interest rate borne by the Series 2011 Bonds during any Weekly Rate Period exceed the lesser of 12% per annum or the maximum contract rate of interest permitted by the laws of the (1) State of Tennessee for the Series 2011 Tennessee Bonds and the Series 2011 Taxable Bonds or the (2) Commonwealth of Virginia for the Series 2011 Virginia Bonds. During the Weekly Rate Periods, (1) interest on the Series 2011 Tax-Exempt Bonds will be computed on the basis of a 365- or 366-day year, as the case may be, and the actual days elapsed and (2) interest on the Series 2011 Taxable Bonds will be computed on the basis of a 360-day year and actual days elapsed.

The determination of any interest rate in accordance with the provisions of the Indentures shall be conclusive and shall be binding upon the Trustee, the Issuers, the Alliance, the Bank, the Remarketing Agent and the Bondholders.

Effective on any Interest Payment Date while the Weekly Rate Periods are in effect, the Alliance shall have the option, with the written approval of the Bank, the applicable Issuer, if any, and the Remarketing Agent, to change the Rate Periods for a Series of the Series 2011 Bonds from the Weekly Rate Periods then in effect to the Medium-Term Rate Periods or to a Fixed Rate Period. Upon such event, the Trustee shall notify the holders of the Series 2011 Bonds of such conversion, and the Series 2011 Bonds shall be subject to mandatory tender for purchase

as described herein. The date on which the interest rate on the Series 2011 Bonds is converted to a Fixed Rate is referred to herein as the "Conversion Date."

Registration and Transfer of Series 2011 Bonds

The Indentures contain the following provisions with respect to registration of transfer and exchange of Series 2011 Bonds. Such provisions do not apply while the Series 2011 Bonds are held by DTC. See Appendix H - "BOOK-ENTRY ONLY SYSTEM."

Any holder of a Series 2011 Bond, in person or by his duly authorized attorney, may register the transfer of his Series 2011 Bond on the Bond Register, upon surrender thereof at the office of the Trustee in East Syracuse, New York, together with a written instrument of transfer (in such form as shall be reasonably satisfactory to the Trustee) executed by the holder or his duly authorized attorney; and upon surrender for registration of transfer of any Series 2011 Bond, an Issuer shall execute and the Trustee shall authenticate and deliver in the name of the designated transferee or transferees a new Series 2011 Bond or Bonds of the same Stated Maturity, aggregate principal amount and tenor as the Series 2011 Bond surrendered and of any Authorized Denomination.

Series 2011 Bonds may be exchanged at the office of the Trustee in East Syracuse, New York, for an equal aggregate principal amount of Series 2011 Bonds of the same Series, Stated Maturity, interest rate, aggregate principal amount and tenor as the Series 2011 Bonds being exchanged and of any Authorized Denomination. The Issuer or the Alliance, as applicable, shall execute and the Trustee shall authenticate and deliver Series 2011 Bonds which the Bondholder making the exchange is entitled to receive, bearing numbers not contemporaneously then outstanding.

Such registrations of transfers or exchanges of Series 2011 Bonds shall be without charge to the holders of such Series 2011 Bonds, but any taxes or other governmental charges required to be paid with respect to the same shall be paid by the Holder of the Series 2011 Bond requesting such registration of transfer or exchange as a condition precedent to the exercise of such privilege. The Trustee shall not be required (a) to transfer or exchange any Series 2011 Bond during the period from a Record Date to an Interest Payment Date or from the Business Day prior to a Special Record Date to the date for payment of Defaulted Interest, or (b) to make any exchange or registration of transfer of any Series 2011 Bonds called for redemption in whole or in part.

The person in whose name any Series 2011 Bond shall be registered shall be deemed and regarded as the absolute owner thereof for all purposes, and payment of, or on account of, either principal or interest shall be made only to or upon the order of such person or his duly authorized attorney, but such registration may be changed as hereinabove described. All such payments shall be valid and effectual to satisfy and discharge the liability upon such Series 2011 Bond to the extent of the sum or sums so paid.

Redemption

The Series 2011 Bonds may not be called for redemption during the Weekly Rate Periods except as described below. This Official Statement does not describe any redemption provisions for Series 2011 Bonds during the Medium Term Period or after the Conversion Date. The Letters of Credit do not secure the payment of any premium due to the optional redemption of Series 2011 Bonds by the Alliance.

Optional Redemption

While the Weekly Rate Periods are in effect, the Series 2011 Bonds of each Series are subject to optional redemption by the Issuer or the Alliance, as applicable, in whole or in part on any Business Day, at the direction of the Alliance, with the prior written consent of the Bank if proceeds drawn under any Letter of Credit will be used for redemption of Series 2011 Bonds, at a redemption price equal to the principal amount thereof plus accrued interest to the Redemption Date.

Extraordinary Optional Redemption

The Series 2011 Bonds are callable for redemption prior to maturity in the event of damage to or destruction of the Property of any member of the Obligated Group or any part thereof or condemnation of the Facilities or any part thereof, if the Net Proceeds of insurance or condemnation received in connection therewith to the extent such Net Proceeds are not applied either to any lawful purposes of the Obligated Group or to the repair, replacement, restoration or reconstruction of the affected Facilities pursuant to the Master Indenture, but only to the extent of the funds provided for in the Master Indenture. If thus called for redemption, Series 2011 Bonds shall be subject to redemption by the Issuer or the Alliance, as applicable, at any time, in whole or in part, and if in part, the Alliance may decide the amount of each Series of Series 2011 Bonds to be redeemed. Such redemption shall be at the principal amount thereof plus accrued interest to the redemption date, and without premium, from the proceeds of such insurance or condemnation award or such sale but not in excess of the amount of such proceeds applied to such purpose. If no direction is given by the Alliance, the Trustee will redeem Series 2011 Bonds of each Series then outstanding pro rata based on the then outstanding principal amount of each Series.

Mandatory Sinking Fund Redemption

Subject to the credit described following the tables below, the Series 2011 Bonds of each Series are subject to Mandatory Sinking Fund Redemption prior to maturity on July 1 in the years and in the principal amounts specified below for each Series of Series 2011 Bonds, at a redemption price equal to 100% of the principal amount thereof plus accrued interest:

Series 2011A Bonds		**Series 2011B Bonds**	
July 1,	**Principal Amount**	**July 1,**	**Principal Amount**
2012	$4,075,000	2012	$ 0
2013	4,240,000	2013	15,000
2014	2,110,000	2014	25,000
2015	2,415,000	2015	95,000
2016	2,540,000	2016	100,000
2017	2,630,000	2017	115,000
2018	3,035,000	2018	470,000
2019	0	2019	695,000
2020	0	2020	735,000
2021	3,555,000	2021	785,000
2022	3,150,000	2022	830,000
2023	3,085,000	2023	940,000
2024	4,225,000	2024	0
2025	3,980,000	2025	0
2026	1,030,000	2026	0
2027	1,020,000	2027	0
2028	780,000	2028	0
2029	590,000	2029	0
2030	330,000	2030	0
2031	410,000	2031	0
2032	17,775,000	2032	0
2033	4,285,000	2033	15,195,000

Series 2011C Bonds	
July 1,	Principal Amount
2012	$ 900,000
2013	755,000
2014	800,000
2015	1,000,000
2016	1,050,000
2017	1,110,000
2018	2,035,000
2019	2,625,000
2020	2,755,000
2021	2,905,000
2022	3,060,000
2023	3,365,000
2024	3,640,000
2025	4,035,000
2026	1,965,000
2027	2,090,000
2028	2,180,000
2029	2,340,000
2030	2,445,000
2031	8,820,000

Series 2011D Bonds	
July 1,	Principal Amount
2012	$ 0
2013	50,000
2014	90,000
2015	360,000
2016	395,000
2017	445,000
2018	1,825,000
2019	2,685,000
2020	2,840,000
2021	3,035,000
2022	3,215,000
2023	3,640,000
2024	6,140,000
2025	6,815,000
2026	3,320,000
2027	3,530,000
2028	3,675,000
2029	3,945,000
2030	4,130,000
2031	10,570,000

Series 2011 Taxable Bonds	
July 1,	Principal Amount
2012	$ 0
2013	15,000
2014	25,000
2015	95,000
2016	105,000
2017	120,000
2018	1,420,000
2019	5,505,000
2020	5,145,000
2021	795,000
2022	845,000
2023	755,000
2024	420,000
2025	505,000
2026	210,000

At its option, to be exercised on or before the forty-fifth (45th) day next preceding any such redemption date, the Alliance may (i) deliver to the Trustee for cancellation bonds of the applicable Series of Series 2011 Bonds to be redeemed, in any aggregate principal amount desired, and/or (ii) receive a credit in respect of its redemption obligation under this mandatory redemption provision for any bonds of the applicable Series of Series 2011 Bonds

of the maturity to be redeemed which prior to said date have been purchased or redeemed (otherwise than through the operation of this mandatory sinking fund redemption provision) and canceled by the Trustee and not theretofore applied as a credit against any redemption obligation under this mandatory sinking fund provision. Each Series 2011 Bond so delivered or previously purchased or redeemed shall be credited by the Trustee at 100% of the principal amount thereof on the obligation of the Issuer or the Alliance, as applicable, on such payment date and any excess shall be credited on future redemption obligations in such order as the Alliance directs, and the principal amount of Series 2011 Bonds of the applicable Series to be redeemed by operation of the mandatory sinking fund provision shall be accordingly reduced. The Alliance shall on or before the forty-fifth (45th) day next preceding each payment date furnish the Trustee with its certificate indicating whether or not and to what extent the provisions of clauses (i) and (ii) of this paragraph are to be availed of with respect to such payment and confirm that funds for the balance of the next succeeding prescribed payment will be paid on or before the next succeeding payment date.

Notice of Redemption

The Trustee shall cause notice of the call for any such redemption identifying the Series 2011 Bonds to be redeemed to be sent not less than 30 nor more than 60 days prior to the Redemption Date (a) by first-class mail postage prepaid, to the holder of each such Series 2011 Bond to be redeemed at his address as it appears on the registration books of the Trustee, (b) by first-class mail, to at least two organizations registered with the Securities and Exchange Commission as securities depositories, (c) to at least one information service of national recognition which disseminates redemption information with respect to municipal securities, and (d) if a Letter of Credit is in effect, to the Bank. Failure to give any notice described in (a), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2011 Bonds with respect to which no such failure has occurred and failure to give any notice described in (b) or (c), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2011 Bonds with respect to which the notice specified in (a) is correctly given. Any notice mailed as described above shall conclusively be presumed to have been given whether or not actually received by any Holder. All Series 2011 Bonds called for redemption shall cease to bear interest on the specified redemption date, provided funds for their redemption are on deposit at the place of payment on the date fixed for redemption.

Partial Redemption of Series 2011 Bonds

If less than all the Series 2011 Bonds of a Series are to be redeemed, the particular Series 2011 Bonds of a Series or portions thereof to be redeemed shall be selected by the Trustee by lot or in such other manner as the Trustee shall deem appropriate, which shall be deemed to include pro rata redemption of Series 2011 Bonds of a Series, and which may provide for the selection for redemption of portions (equal to Authorized Denominations) of the principal of Series 2011 Bonds of a Series; provided that (a) if at the time of selection of any Series 2011 Bonds for redemption any Series 2011 Bonds of a Series are Pledged Bonds or Borrower Bonds, such Pledged Bonds or Borrower Bonds shall be selected for redemption prior to any other Series 2011 Bonds of such Series, and (b) if at the time of selection, the Trustee has received notice of tender of any Series 2011 Bonds for which the Optional Tender Date will be on or after the Redemption Date, the Trustee (after redeeming all Series 2011 Bonds to which clause (a) applies) shall select such Tendered Bonds for redemption prior to any Series 2011 Bonds of such Series, other than Pledged Bonds or Borrower Bonds.

Any Series 2011 Bond which is to be redeemed only in part shall be surrendered to the Trustee (a) for payment of the Redemption Price (including accrued interest thereon to the Redemption Date) of the portion thereof called for redemption and (b) for exchange for Series 2011 Bonds in any Authorized Denomination or denominations in aggregate principal amount equal to the unredeemed portion of such Series 2011 Bond, without charge therefor.

Notwithstanding the foregoing, in the event that the depository for the Series 2011 Bonds is DTC, the Trustee will follow the procedure for redemption, and selection of Series 2011 Bonds for redemption, prescribed by DTC.

Purchase of Series 2011 Bonds in Lieu of Redemption

In lieu of redeeming Series 2011 Bonds, the Trustee may, at the request of the Alliance, use funds otherwise available under the Indenture for redemption of Series 2011 Bonds to purchase Series 2011 Bonds identified by the Alliance in the open market for cancellation at a price specified by the Alliance not exceeding the Redemption Price then applicable under the Indenture. In the case of any extraordinary redemption or any purchase and cancellation of the Series 2011 Bonds, the Alliance shall receive credit against its required deposits to the Bond Sinking Fund with respect to Series 2011 Bonds of the Series and maturity redeemed or purchased in such order as the Alliance elects prior to such extraordinary redemption or purchase and cancellation or, if no election is made, in the inverse order thereof.

Tender and Purchase of Series 2011 Bonds

Purchase of Series 2011 Bonds at Option of Holder

While the Weekly Rate Periods are in effect, the Trustee, as Tender Agent and acting on behalf of the Alliance and for the benefit of the Bondholders, shall purchase any Series 2011 Bond (other than Pledged Bonds and Borrower Bonds), in whole or in part in Authorized Denominations upon the demand of the holder thereof at a purchase price equal to the principal amount thereof plus accrued interest, if any, to the date of purchase, for the account of the Alliance, but only upon (a) delivery to the Trustee and the Remarketing Agent at their respective principal offices (St. Louis, Missouri for the Trustee) of a written notice, or at the option of the Trustee or the Remarketing Agent (with respect to their respective notices), telephonic notice confirmed in writing, from the Holder of such Series 2011 Bond (an "Optional Tender Notice") which shall state (1) the principal amount or portions of such Series 2011 Bond being tendered, the number of the Series 2011 Bond being tendered and the name of the Holder thereof and (2) the date such Series 2011 Bond or portion thereof shall be purchased pursuant to the Indenture (the "Optional Tender Date"), which date shall be a Business Day not later than 3:00 p.m., New York City time on the Business Day that is five Business Days prior to the date of receipt of such Optional Tender Notice by the Remarketing Agent and the Trustee and (b) delivery of such Series 2011 Bond (with all necessary endorsements) to the Trustee, at its office in East Syracuse, New York, at or prior to 10:00 a.m., New York City time, on the first Business Day prior to the date of purchase specified in the aforesaid notice; provided, however, that payment of the purchase price of such Series 2011 Bonds shall be made only if the Series 2011 Bonds so delivered to the Trustee, as Tender Agent, shall conform in all respects to the description thereof in the aforesaid notice. Payment of such purchase price shall be made by check unless the Bondholder's Optional Tender Notice contains instructions to the Trustee to wire such purchase price to a particular account. If the date that a Series 2011 Bond is to be purchased is after a Record Date but before the next succeeding Interest Payment Date, the owner of such Series 2011 Bond shall also be required to deliver to the Trustee a due bill instructing that the interest due on the next succeeding Interest Payment Date be paid to the person who purchases such Series 2011 Bond on the purchase date.

On the Optional Tender Date, the Trustee, as Tender Agent, shall purchase the Series 2011 Bond or portion thereof identified in such Optional Tender Notice from the Holder thereof for the account of the Alliance, at a purchase price equal to the principal amount or portion thereof being tendered plus accrued interest, but only from funds provided by the Alliance, including moneys drawn under the Letter of Credit.

Any Series 2011 Bonds which are not tendered on an Optional Tender Date pursuant to an Optional Tender Notice (the "Untendered Bonds"), for which there has been irrevocably deposited in trust with the Trustee an amount sufficient to pay the purchase price thereof, shall be deemed to have been tendered for purchase and purchased as described herein. Holders of Untendered Bonds shall not be entitled to any payment (including any interest to accrue subsequent to the Optional Tender Date) other than the purchase price for such Untendered Bonds, and the Holders of such Untendered Bonds shall no longer be entitled to the benefits of the Indenture, except for the purpose of payment of the purchase price thereof. Replacement Bonds shall be issued in place of such Untendered Bonds and after the issuance of such Replacement Bonds, such Untendered Bonds shall be deemed to have been purchased and shall no longer be Outstanding under the Indenture.

Mandatory Purchase Upon Conversion Date

The Series 2011 Bonds are required to be tendered for purchase on each Conversion Date or any Proposed Conversion Date. Upon receipt of notice from the Alliance establishing the Proposed Conversion Date and certain other documentation required by the Indenture, the Trustee shall give Notice by Mail to the Bondholders at least 30 days before the Proposed Conversion Date that the Proposed Conversion Date is a Mandatory Tender Date. Such notice shall state (a) that the interest rate on the Series 2011 Bonds will be converted to a Fixed Rate; (b) the Conversion Date; (c) the date by which (1) the Preliminary Fixed Rate that is required to be determined pursuant to the Indenture is to be determined and (2) the Bondholders may contact the Trustee (and the name and telephone number of the person whom the Bondholders may contact) to obtain the Preliminary Fixed Rate; (d) the date by which (1) the Remarketing Agent is required to determine the Fixed Rate, (2) the Bondholders may contact the Trustee (and the name and telephone number of the person whom the Bondholders may contact) to obtain the Fixed Rate, and (3) the Trustee will notify upon request the Bondholders of the Fixed Rate; (e) that subsequent to the conversion to a Fixed Rate (1) any ratings of the Rating Agency or Agencies then rating the Series 2011 Bonds may be withdrawn or changed (if such is the case) and (2) the Bondholders will no longer have the right to tender their Series 2011 Bonds to the Trustee for purchase under the Indenture; (f) the last date on which the Bondholders' right to tender Series 2011 Bonds may be exercised; (g) that the Series 2011 Bonds will not be entitled to the benefit of the Letter of Credit or a Substitute Letter of Credit after the Conversion Date, if such is the case; (h) that there will be a failure of conversion (1) if the Fixed Rate is less than the Preliminary Fixed Rate, (2) if the Opinion of Bond Counsel required in connection with such a conversion is withdrawn prior to the Conversion Date, (3) if the Remarketing Agent fails to determine the Preliminary Fixed Rate or Fixed Rate or (4) if the Alliance revokes its request to convert the interest rate on the Series 2011 Bonds to a Fixed Rate; (i) that such failure of conversion shall result in the Series 2011 Bonds bearing interest at a Weekly Rate; (j) the Termination Date of the Letter of Credit; and (k) that, on the Proposed Conversion Date, the Bondholder shall have no further rights under such Series 2011 Bond or Bonds except to receive the principal of the Series 2011 Bond or Bonds upon presentation and surrender of such Series 2011 Bond or Bonds to the Trustee.

On the Proposed Conversion Date, whether or not a Failed Conversion as described below has occurred, the Trustee shall purchase all outstanding Series 2011 Bonds (except Pledged Bonds and Borrower Bonds) from the Holders thereof, who shall also have delivered such Series 2011 Bonds to the Trustee, all as above described.

If (i) the Fixed Rate as determined by the Remarketing Agent is less than the Preliminary Fixed Rate, (ii) the Remarketing Agent fails to determine the Preliminary Fixed Rate or Fixed Rate, (iii) the Opinion of Bond Counsel required with respect to the conversion to the Fixed Rate is withdrawn prior to the Conversion Date or, (iv) the Alliance revokes its request to convert the interest rate on the Series 2011 Bonds to a Fixed Rate, then a failed conversion shall be deemed to have occurred (a "Failed Conversion"). In the event of a Failed Conversion, the interest rate on the Series 2011 Bonds will be the Weekly Rate, and the Weekly Rate Periods shall be in effect. If the Weekly Rate Periods were not in effect prior to the Proposed Conversion Date, the Proposed Conversion Date shall be deemed to be an Adjustment Date for a Weekly Rate Period beginning on such date.

Mandatory Purchase Upon Conversion to Medium-Term Rate Periods

The Series 2011 Bonds are required to be tendered for purchase on the first day of each period at which the Series 2011 Bonds bear interest at the Medium-Term Rate, each such date being an Adjustment Date for the Medium-Term Rate Periods. The Trustee shall give Notice by Mail to the Bondholders, the Remarketing Agent, the Issuer and the Bank at least 30 days before each Adjustment Date for the Medium-Term Rate Periods that such date is a Mandatory Tender Date. Such notice shall state (a) the Mandatory Tender Date; (b) the date on which the Remarketing Agent is required to determine the length of the Medium-Term Rate Period that begins on such Date; (c) the date by which the Remarketing Agent is required to determine the interest rate for such Medium-Term Rate Period; (d) that the Bondholders may contact the Trustee (and the name and telephone number of the person whom the Bondholders may contact) to obtain the length of the Medium-Term Rate Period and the interest rate for such Medium-Term Rate Period on or after the date of its determination; (e) the Interest Payment Date and Record Date for such Medium-Term Rate Period; (f) that during the Medium-Term Rate Period, the Bondholders will no longer have the right to tender their Series 2011 Bonds to the Trustee for purchase under the Indenture and the last day on which the Bondholders' right to tender Series 2011 Bonds may be exercised; (g) the rating of the Series 2011 Bonds by each Rating Agency, if the Series 2011 Bonds are to be rated, after the Mandatory Tender Date; and (h) that, on

such Mandatory Tender Date, the Bondholder shall have no further rights under such Series 2011 Bond or Bonds except to receive the principal of the Series 2011 Bond or Bonds upon presentation and surrender of such Series 2011 Bond or Bonds to the Trustee.

Mandatory Purchase Upon Substitution Tender Date

The Series 2011 Bonds of a Series are required to be tendered for purchase on the fifth Business Day prior to the effective date of any Substitute Letter of Credit (the "Substitution Tender Date") for such Series. The Trustee shall give Notice by Mail to the Bondholders, the Remarketing Agent, the Issuer, the Alliance and the Bank at least 30 days before the Substitution Tender Date that such date will be a Mandatory Tender Date. Such notice shall state: (i) the Substitution Tender Date; (ii) the identity of the bank that is issuing the Substitute Letter of Credit; (iii) the rating of the Series 2011 Bonds by each Rating Agency, if the Series 2011 Bonds are to be rated, after the delivery of the Substitute Letter of Credit; and (iv) that, on such Mandatory Tender Date, interest shall cease to accrue with respect to such Bondholder's Series 2011 Bond or Bonds on such date and the Bondholder shall have no further rights under such Series 2011 Bond or Bonds except to receive the principal of the Series 2011 Bond or Bonds upon presentation and surrender of such Series 2011 Bond or Bonds to the Trustee.

Mandatory Purchase on Termination of Letter of Credit

The Series 2011 Bonds of each Series are subject to mandatory tender for purchase in whole on the second Business Day prior to the Termination Date of the Letter of Credit securing such Series.

No Purchase After Event of Default

Anything in the Indentures to the contrary notwithstanding, there shall be no purchases of Series 2011 Bonds pursuant to such Indenture if there shall have occurred and be continuing an Event of Default of which the Trustee has knowledge that immediately requires the acceleration of the Series 2011 Bonds under such Indenture.

Defeasance

If the applicable Issuer deposits with the applicable Bond Trustee funds, evidenced by moneys or Defeasance Investments (as defined in Appendix D) the principal of and interest on which, when due, will be sufficient to pay the principal or Redemption Price of any Series of Series 2011 Bonds, by call for redemption or otherwise, together with interest accrued to the due date or the redemption date, as appropriate, in accordance with the terms of the Indentures, such Series of Series 2011 Bonds shall no longer be deemed to be Outstanding under the applicable Indenture. Interest on such Series of Series 2011 Bonds, as appropriate, will cease to accrue on the due date or the redemption date, as appropriate, and from and after the date of such deposit of funds with the Bond Trustee the holders of such Series of Series 2011 Bonds will be restricted to the funds so deposited as provided in the Indentures.

PLAN OF FINANCE

Application of Proceeds

The proceeds of the Series 2011 Tennessee Bonds will be loaned by the Tennessee Issuer to the Alliance pursuant to Loan Agreements dated as of October 1, 2011, and used (1) to finance certain capital improvements and equipment acquisitions at the facilities owned and/or operated by the Alliance in the State of Tennessee, and (2) to pay certain expenses incurred in connection with the issuance of the Series 2011 Tennessee Bonds.

The proceeds of the Series 2011C Bonds will be loaned by the Virginia Issuer to the Alliance, Smyth and Norton pursuant to a Loan Agreement dated as of October 1, 2011. The proceeds of the Series 2011C Bonds will be used (1) to refinance $11,200,000 of the Hospital Refunding and Improvement Revenue Bonds (Norton Community Hospital, Inc.), Series 2001 (the "Refunded Norton Bonds"), issued by the Industrial Development Authority of the City of Norton, Virginia, for the benefit of Norton; (2) to finance certain capital improvements and equipment acquisitions at the facilities owned and/or operated by Smyth and Norton; and (3) to pay certain expenses incurred in connection with the issuance of the Series 2011C Bonds.

The proceeds of the Series 2011D Bonds will be loaned by the Virginia Issuer to the Alliance, Smyth and Johnston Memorial Hospital ("JMH") pursuant to a Loan Agreement dated as of October 1, 2011. The proceeds of the Series 2011D Bonds will be used (1) to finance certain capital improvements and equipment acquisitions at the facilities owned and/or operated by Smyth and JMH and (2) to pay certain expenses incurred in connection with the issuance of the Series 2011D Bonds.

The proceeds of the Series 2011 Taxable Bonds will be loaned to the Alliance pursuant to a Bond Purchase Agreement dated as of October 19, 2011, between the Alliance and Merrill Lynch, Pierce, Fenner & Smith Incorporated. The proceeds of the Series 2011 Taxable Bonds will be used (1) to finance capital improvements and equipment acquisitions at facilities owned by Smyth and Blue Ridge Medical Management Corporation, an affiliate of the Alliance; and (2) to pay certain expenses incurred in connection with the issuance of the Series 2011 Taxable Bonds.

Refunding of Refunded Norton Bonds

A portion of the proceeds of the Series 2011C Bonds will be deposited in an escrow fund (the "Escrow Fund") to be held by U.S. Bank National Association, as escrow agent for the Refunded Norton Bonds , pursuant to a Refunding Trust Agreement (the "Refunding Agreement") to be dated the date of delivery of the Series 2011C Bonds. The Refunding Agreement will provide that cash will be deposited in the Escrow Fund in an amount sufficient to pay the redemption price of the Refunded Bonds on the date of redemption, December 1, 2011.

Verification of Mathematical Computations

The Arbitrage Group, Inc., independent arbitrage consultants, will verify the arithmetical accuracy of certain mathematical computations relating to the sufficiency of the moneys deposited in the Escrow Fund to pay the redemption prices of the Refunded Norton Bonds at redemption prices equal to the respective principal amounts of the Refunded Bonds to be redeemed, plus interest accrued and unpaid to such redemption date, plus the applicable premium based on information provided by the Alliance, and such verification will be relied upon by Bond Counsel to support its opinion that interest on the Series 2011 Tax-Exempt Bonds will not be included in gross income for federal income tax purposes. Such computations were based solely upon information supplied by the Financial Advisor. The Arbitrage Group, Inc. has restricted its procedures to verifying the arithmetical accuracy of certain computations and has not made any study or evaluation of the assumptions and information upon which the computations are based and, accordingly, has not expressed an opinion on the data used, the reasonableness of the assumptions, or the achievability of future events.

Sources and Uses of Funds

Sources of Funds	**2011A**	**2011B**	**2011C**	**2011D**	**2011E**	**Total**
Principal Amount	$65,260,000	$20,000,000	$49,875,000	$60,705,000	$15,960,000	$211,800,000
Funds on Hand	0	0	2,283,559	0	0	2,283,559
	65,260,000	20,000,000	52,158,559	60,705,000	15,960,000	$214,083,559

Uses of Funds	**2011A**	**2011B**	**2011C**	**2011D**	**2011E**	**Total**
Projects	$19,446,502	$12,314,067	$37,432,000	$57,801,008	$0	$126,993,577
Equipment	21,659,647	7,450,648	1,716,490	2,150,304	0	32,977,089
Refunding of Long-term Debt	0	0	12,377,475	0	0	12,377,475
Refinancing of Loans and Leases	23,421,513	0	0	0	15,782,533	39,204,046
Costs of Issuance	732,338	235,285	632,594	753,688	177,467	2,531,372
	$65,260,000	$20,000,000	$52,158,559	$60,705,000	$15,960,000	$214,083,559

Current and Pro Forma Long-Term Debt

The left column of the following table reflects the total outstanding debt of the Alliance under the Master Indenture as of June 30, 2011, prior to the issuance of the Series 2011 Bonds. The right column of the following table shows the outstanding debt of the Alliance under the Master Indenture as of June 30, 2011, but adjusted to show the effect of the issuance of the Series 2011 Bonds and the planned redemption of (1) $115,135,000 of the outstanding principal amount of the Tennessee Issuer's Hospital Revenue Bonds, Series 2007B-1, and (2) $29,405,000 of the outstanding principal amount of the Tennessee Issuer's Hospital Revenue Bonds, Series 2007B-3. The table below and in the immediate following section does not include the indebtedness of certain entities controlled by the Alliance that are not Obligated Issuers.

Outstanding Long-Term Debt (at June 30, 2011)		Pro Forma Long-Term Debt (at June 30, 2011)	
Description	**Principal Amount**	**Description**	**Principal Amount**
Debt:		***Debt:***	
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	$38,607,500[(1)]	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	$38,607,500[(1)]
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	34,325,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	34,325,000
Mountain States Health Alliance Taxable Note, Series 2000D	14,790,000	Mountain States Health Alliance Taxable Note, Series 2000D	14,790,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	23,100,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	23,100,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	169,630,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	169,630,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	144,400,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	29,265,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-2	105,000,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-2	105,000,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-3	58,500,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-3	29,095,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2008A	13,245,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2008A	13,245,000
Industrial Development Authority of Russell County Hospital Revenue Bonds, Series 2008B	53,855,000	Industrial Development Authority of Russell County Hospital Revenue Bonds, Series 2008B	53,855,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,560,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,560,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,535,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,535,000
Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	115,955,000	Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	115,955,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	168,080,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	168,080,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	35,935,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	35,935,000
		The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011A	65,260,000
		The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011B	20,000,000
		Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011C	49,875,000
		Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011D	60,705,000
		Mountain States Health Alliance Taxable Bonds, Series 2011E	15,960,000
Total Long-Term Debt	**$986,517,500**	**Total Long-Term Debt**	**$1,053,777,500**
Less: 2000 Reserve Fund	$ 7,000,000	Less: 2000 Reserve Fund	$7,000,000
2006A Reserve Fund	17,303,000	2006A Reserve Fund	17,303,000
2009A, B and C Reserve Funds	12,131,762	2009A, B and C Reserve Funds	12,131,762
2010A and B Reserve Funds	18,352,884	2010A and B Reserve Funds	18,352,884
NET TOTAL LONG-TERM DEBT	**$931,729,854**	**NET TOTAL LONG-TERM DEBT**	**$998,989,854**

[(1)] Value of CABS accreted to June 30, 2011.

[(2)] Amounts in this reserve fund may be withdrawn at any time prior to an event requiring funding of Debt Service Reserve Funds.

Estimated Annual Debt Service Requirements

The following table reflects the estimated outstanding debt service obligations of the Alliance on all long term indebtedness secured under the Master Indenture following the issuance of the Series 2011 Bonds. The estimated annual debt service with respect to outstanding indebtedness assumes a 3.50% interest rate on all variable rate bonds, and does not take into account any interest rate hedges that may exist or may be executed in the future.

	Estimated Annual Debt Service Requirements Series 2011 Bonds				
Year Ending July 1	Principal	Interest	Annual Debt Service	Estimated Annual Debt Service on Outstanding Indebtedness	Estimated Total Annual Long-Term Debt Service Requirements
2012	$ 4,975,000	$7,413,000	$12,388,000	$63,980,794	$76,368,794
2013	5,075,000	7,238,875	12,313,875	63,911,294	76,225,169
2014	3,050,000	7,061,250	10,111,250	63,813,281	73,924,531
2015	3,965,000	6,954,500	10,919,500	63,731,169	74,650,669
2016	4,190,000	6,815,725	11,005,725	63,636,844	74,642,569
2017	4,420,000	6,669,075	11,089,075	63,543,156	74,632,231
2018	8,785,000	6,514,375	15,299,375	59,294,481	74,593,856
2019	11,510,000	6,206,900	17,716,900	56,802,156	74,519,056
2020	11,475,000	5,804,050	17,279,050	56,592,913	73,871,963
2021	11,075,000	5,402,425	16,477,425	56,342,863	72,820,288
2022	11,100,000	5,014,800	16,114,800	56,080,694	72,195,494
2023	11,785,000	4,626,300	16,411,300	55,817,100	72,228,400
2024	14,425,000	4,213,825	18,638,825	52,797,156	71,435,981
2025	15,335,000	3,708,950	19,043,950	51,708,156	70,752,106
2026	6,525,000	3,172,225	9,697,225	60,670,569	70,367,794
2027	6,640,000	2,943,850	9,583,850	60,459,681	70,043,531
2028	6,635,000	2,711,450	9,346,450	60,386,894	69,733,344
2029	6,875,000	2,479,225	9,354,225	60,251,281	69,605,506
2030	6,905,000	2,238,600	9,143,600	60,134,594	69,278,194
2031	19,800,000	1,996,925	21,796,925	46,943,263	68,740,188
2032	17,775,000	1,303,925	19,078,925	46,069,300	65,148,225
2033	19,480,000	681,800	20,161,800	45,138,300	65,300,100
2034	-	-	-	66,714,488	66,714,488
2035	-	-	-	66,685,563	66,685,563
2036	-	-	-	66,656,063	66,656,063
2037	-	-	-	66,621,338	66,621,338
2038	-	-	-	66,529,213	66,529,213

JMH Financing

Shortly after the issuance of the Series 2011 Bonds, it is expected that the Virginia Issuer will issue its approximately $25,000,000 Hospital Facility Revenue Refunding and Improvement Bonds (Johnston Memorial Hospital Project), Series 2011 (the "JMH Bonds"), for the benefit of JMH. JMH is not a member of the Obligated Group and the Obligated Issuers will not be required to pay debt service on the JMH Bonds. The JMH Bonds are not included in the tables in the sections "Current and Pro Forma Long Term Debt" and "Estimated Annual Debt Service Requirements" above.

SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2011 BONDS

Special, Limited Obligations of the Issuers

The Series 2011 Tennessee Bonds will be issued under and secured by the Tennessee Bond Indentures and are payable from moneys received by the Tennessee Bond Trustee from the Alliance, as further described in "Trust Estate" below. The Series 2011 Virginia Bonds will be issued under and secured by the Virginia Bond Indentures and are payable from moneys received by the Virginia Bond Trustee from the Alliance, as further described in "Trust Estate" below.

Contemporaneously with the issuance of the Series 2011 Tennessee Bonds and the Series 2011 Virginia Bonds, the Alliance will issue the Series 2011 Taxable Bonds, which are secured on a parity with the Series 2011 Tax-Exempt Obligations.

Trust Estate

The Series 2011 Bonds of each Series are payable from the respective Trust Estates under the Bond Indentures, which consist of (i) payments or prepayments to be made on the Series 2011 Obligations, and any additional obligations of the Alliance to the respective Issuer to the extent such additional obligations may be pledged under the Bond Indentures in the future; (ii) other payments under the Loan Agreements (other than fees and expenses payable to the Issuers and the Issuers' rights to indemnification in certain circumstances); (iii) all moneys and investments held under the applicable Bond Indenture, but not including amounts required to be paid into the funds established under the applicable Bond Indenture; and (iv) in certain circumstances, proceeds from certain insurance and condemnation awards.

Pursuant to the Series 2011 Obligations, the Alliance is required to make payments to the applicable Bond Trustee for deposit into the Debt Service Fund established under the applicable Bond Indenture, at the times and in amounts sufficient to pay the principal of and interest on the Series 2011 Bonds.

Payment of principal and interest on the Series 2011 Bonds will not be secured by any encumbrance, mortgage or other pledge of any property of any Issuer. **The Series 2011 Bonds will not constitute a debt or indebtedness of any state or any political subdivision or agency thereof, including The Health and Educational Facilities Board of the City of Johnson City, Tennessee, and the Industrial Development Authority of Smyth County (Virginia) within the meaning of any constitutional or statutory provision or limitation. The Issuers do not have taxing power.**

Master Indenture Covenants

In the Master Indenture, the Alliance has made certain covenants, on behalf of itself and the Obligated Group (as defined in the Master Indenture), regarding maintenance of fees and rates, and any future Obligated Issuer would be required to make similar covenants upon joining the Obligated Group. These covenants provide, among other matters, that each Obligated Issuer (including the Alliance) will continue to impose such fees as are included within the Gross Revenues, operate on a revenue producing basis, and charge such fees and rates for its facilities and services and exercise such skill and diligence as to provide income from its property together with other available funds sufficient to pay promptly all payments of principal and interest on its indebtedness secured by the Master Indenture, all expenses of operation, maintenance, and repair of its property subject to the Master Indenture, and all other payments required to be made by it under the Master Indenture to the extent permitted by law. Each Obligated Issuer (including the Alliance) also covenants to use its best efforts to maintain in each Fiscal Year a ratio of total Income Available for Debt Service to Maximum Annual Debt Service for all Obligated Issuers at least equal to 1.30 to 1. Each Obligated Issuer (including the Alliance) further covenants that it will from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of the Master Indenture described in this paragraph. See Appendix D - "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges."

The Master Indenture defines "Income Available for Debt Service" of the Alliance or other Obligated Issuer to mean, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income after tax, as determined in accordance with generally accepted accounting principals, to which shall be added, in either case, (i) depreciation, (ii) amortization, (iii) interest expense on Long-Term Indebtedness (as defined in the Master Indenture) and (iv) to the extent not already included, contributions and donations and from which shall be excluded any extraordinary items, any impairment losses, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or other disposition of assets not made in the ordinary course of business, provided, however, that (a) no determination of Income Available for Debt Service will take into account any gains or losses resulting from the periodic valuation of investments or Hedge Agreements that do not involve the sale, transfer or other disposition of any such investment or Hedge Agreement or the termination of any Hedge Agreement and (b) a person may include in its net income such person's share of the net income of any

person controlled by such person or in whom such person has a legal interest. The Master Indenture contains provisions relating to the calculation of Maximum Annual Debt Service that provides for reallocation of amounts due on balloon indebtedness and assumptions as to the interest rates on variable rate indebtedness and payment of guaranties. For financial information of the Alliance, see Appendix A and the Alliance's audited consolidated financial statements for the fiscal year ended June 30, 2010 and June 30, 2009, included as Appendix B and its unaudited consolidated financial statements for the fiscal year ended June 30, 2011, included as Appendix C. For a more complete description of the covenants under the Master Indenture, see "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges" in Appendix D.

Only Obligated Issuers are obligated to make payments on the Series 2011 Bonds and to abide by the covenants under the Master Indenture. The audited and unaudited financial statements included as Appendices B and C reflect the assets and operations of entities that are not Obligated Issuers. See Appendix A − "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

Amendment of Master Indenture

By purchasing the Series 2011 Bonds, the initial holders thereof will consent to an amendment to the definition of "Debt Service Requirement" in the Master Indenture. Such amendment will not become effective immediately and will become effective only upon receipt of the consent of the required percentage of bondholders and credit enhancers under the terms of the Master Indenture.

Both the existing definition and the proposed amended definition are set forth in Appendix D, "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS." The definition of "Debt Service Requirement" is utilized in calculations under both the additional debt test and the rate covenant under the Master Indenture, and such amendment may in certain circumstances increase or decrease the amount of the Debt Service Requirement in any required calculation. See "Additional Long-Term Indebtedness" and "Rates and Charges" in "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE" in Appendix D.

Pledged Assets; Mortgage

Currently, the Series 2011 Bonds are secured by the applicable Trust Estate, including the assignment of the applicable Series 2011 Obligation. As security for its Master Obligations, the Alliance has granted to the Master Trustee a security interest in its Pledged Assets, subject to Permitted Liens. The Pledged Assets consist of: Receivables, Inventory, Equipment, General Intangibles, Contracts and Contract Rights, Government Approvals, Fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets. For a definition of these terms see Appendix D - "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS." Financing statements will be filed in the appropriate records of the Office of the Tennessee Secretary of State to perfect the security interest in Pledged Assets and Equipment to the extent possible by such filing. Continuation statements meeting the requirements of the Uniform Commercial Code of Tennessee (the "UCC") must be filed every five years to continue the perfection of such security interest. The security interest in the Pledged Assets and Equipment is subject to Permitted Liens that exist prior to or may be created subsequent to the time the security interest granted by the Master Indenture attaches.

The security interest in any item of inventory will be inferior to the interest of a buyer in the ordinary course of business and will be inferior to a purchase money security interest, as defined in the UCC, perfected in connection with the sale to an Obligated Issuer of such item. The lien on certain other Pledged Assets may not be enforceable against third parties unless such other Pledged Assets are transferred to the Master Trustee (which transfer Obligated Issuers are not required by the Master Indenture to make prior to an Event of Default thereunder and which transfer may be set aside if it occurs within 90 days of the filing of a petition in bankruptcy) and is subject to exception under the UCC. The federal government may in the future proscribe or restrict the assignment of rights arising out of Medicare, Medicaid or other federal programs.

As a condition to becoming a Member of the Obligated Group, an entity must grant to the Master Trustee a security interest in its Pledged Assets.

Pursuant to the Master Indenture, the Obligated Issuers agree that they will not create or suffer to be created or exist any Lien other than Permitted Liens, as defined under "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS" in Appendix D, upon any of their facilities now owned or hereafter acquired.

The Series 2011 Obligations are also secured by a mortgage on the Johnson City Medical Center located in Johnson City, Tennessee, and the Sycamore Shoals Hospital facility in Elizabethton, Tennessee (together, the "Mortgaged Property"). Such mortgage secures all Master Obligations issued under the Master Indenture.

Subject to certain conditions, in case of the failure of the Obligated Issuers to make any payment on the Master Obligations when due or upon any other event of default under the Master Indenture, the Master Trustee may, after such notice as is required by the Master Indenture and the applicable security instruments, take possession of Mortgaged Property or, upon such public notice as required by Tennessee statute, sell the Mortgaged Property, and apply the proceeds to payment of principal of and interest on the Master Obligations (and thereby on the Series 2011 Bonds) on a parity basis with any other Master Obligation.

Additional Indebtedness

The Alliance has certain debt outstanding under the Master Indenture. The Master Indenture permits the Alliance and any other members of the Obligated Group to incur Additional Indebtedness (including Guaranties), all upon the terms and subject to the conditions specified therein. Such Additional Indebtedness may, but need not, be evidenced or secured by a Master Obligation. Additional Indebtedness may be issued to the Issuer or to persons other than the Issuer.

The reimbursement obligations of the Alliance with respect to the Letters of Credit will also be secured under the Master Indenture.

Except as noted in the preceding paragraph, the Master Indenture, the Alliance and each other Obligated Issuer agrees that it will not incur other Additional Indebtedness unless it can demonstrate that certain coverage ratios have been and will be met between debt service obligations and Income Available for Debt Service. Under the Master Indenture, Additional Indebtedness may be Long-Term Indebtedness or Short-Term Indebtedness. The Master Indenture allows any future Obligated Issuer to incur Additional Indebtedness under the Master Indenture as a Master Obligation constituting the joint and several obligation of the Alliance and all other Obligated Issuers and subject to cross-guarantees of all Obligated Issuers, including the Alliance. Except to the extent entitled to the benefits of additional security as permitted by the Master Indenture and except for Subordinated Indebtedness, all Master Obligations will be equally and ratably secured by the Master Indenture. See Appendix D - "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE."

Subject to certain conditions set forth in the Master Indenture, Additional Indebtedness incurred by any Member of the Obligated Group may be secured by security which does not extend to any other Indebtedness. Such security may include Liens on the Property (including health care facilities) of the Members of the Obligated Group, letters or lines of credit or insurance, and could also consist of Liens on cash or securities deposited or held in any depreciation reserve, debt service or interest reserve, debt service or similar fund established pursuant to the terms of any Supplemental Master Indenture, Related Bond Indenture or Related Loan Document. The Master Indenture provides that Supplemental Master Indentures pursuant to which one or more series of Master Obligations entitled to additional security are issued may provide for such amendments to provisions of the Master Indenture, including the provisions thereof relating to the exercise of remedies upon the occurrence of an event of default, as are necessary to provide for such security and to permit realization upon such security solely for the benefit of the Master Obligation secured thereby.

Defeasance

If the interest on, and the principal or redemption price (as the case may be) of a Series of the Series 2011 Bonds have been paid, or the required amount of money and/or Defeasance Investment (see "SUMMARY OF THE

FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS" in Appendix D) have been deposited with the applicable Bond Trustee to provide sufficient amounts to pay the principal of, and premium, if any, and interest due and to become due on such Series of Series 2011 Bonds on or prior to the redemption date or maturity date thereof, such Series of Series 2011 Bonds shall no longer be deemed outstanding under the applicable Bond Indenture and will no longer be secured thereby. If all Series 2011 Bonds of a Series have been so provided for, the applicable Bond Trustee shall cancel and discharge the applicable Bond Indenture. See "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE - Defeasance" in Appendix D.

Bankruptcy

The lien on the Pledged Assets and Equipment given for the benefit of holders of Master Obligations (and thereby the Series 2011 Bonds) are generally superior to the claims of other creditors (subject to the limitations set forth above). However, bankruptcy and similar proceedings and usual equity principles may affect the enforcement of rights to such security. If such security is inadequate for payment in full of the Bonds, bankruptcy proceedings and usual equity principles may also limit any attempt by the Master Trustee to seek payment from other property of the Alliance or future Obligated Issuers. In particular, federal bankruptcy law permits adoption of a reorganization plan even though it has not been accepted by the holders of a majority in aggregate principal amount of the Bonds if the holders are provided with the benefit of their original lien or the "indubitable equivalent." In addition, if the bankruptcy court concludes that the holders have "adequate protection," it may (1) substitute other security for the security subject to the lien of the holders and (2) subordinate the lien of the holders to claims by entities or persons supplying post petition financing to the Alliance after bankruptcy. Furthermore, the reasonable and necessary costs and expenses of preserving or disposing of the Pledged Assets and Equipment in a bankruptcy may, in certain circumstances, reduce the value of the lien on the Pledged Assets and Equipment to the extent such costs and expenses benefit the Master Trustee (and holders). In the event of the bankruptcy of the Alliance, the amount realized by the holders might depend on the bankruptcy court's interpretation of "indubitable equivalent" and "adequate protection" under the then existing circumstances, which may result in a reduction in the security for or proceeds available to the holders.

THE LETTERS OF CREDIT

Terms of the Letters of Credit

The timely payment of the principal of and interest on the Series 2011 Bonds and the purchase price of each Series of the Series 2011 Bonds will be secured by a corresponding irrevocable transferable direct-pay letter of credit (each, a "Letter of Credit") issued by the respective Bank in a stated amount equal to the aggregate principal amount of the respective Series 2011 Bonds outstanding at any time plus 37 days' interest thereon, calculated at the rate of 12% per annum (the "Maximum Rate"). Each Letter of Credit will be issued pursuant to a Reimbursement Agreement dated as of October 19, 2011 (each a "Reimbursement Agreement" and, together, the "Reimbursement Agreements"), among the Obligated Issuers and the respective Bank and any syndicate lenders. The obligations on the part of the Alliance to reimburse the Bank for draws made under each respective Letter of Credit, and to pay to the Bank all other amounts due under the Reimbursement Agreement, will be evidenced by Obligations (as defined in the Master Indenture) issued and secured under the Master Indenture.

Each respective Letter of Credit will expire on October 19, 2014, unless otherwise terminated or extended. Each Letter of Credit shall expire earlier than such expiration date upon the first to occur of (a) the Business Day following a Conversion Date (b) the date of receipt by the Bank of notice from the Trustee that a Substitute Letter of Credit, as described below, has been issued in substitution for the Letter of Credit; (c) the date on which the Bank honors the final drawing or drawings available; and (d) the date on which the Trustee certifies that no Series 2011 Bonds of the Series are outstanding. At the request of the Alliance, and the consent of the Bank and any syndicate lenders, the term of the respective Letter of Credit may be extended by one year. Such consent shall be at the sole discretion of the Bank and any syndicate lenders, subject to earlier termination or extension at the option of the Bank. Pursuant to the Indentures and subject to certain conditions described herein, prior to the expiration of the Letter of Credit or any other Letter of Credit, the Alliance may deliver to the Trustee a substitute Letter of Credit. Each respective Letter of Credit and any substitute Letter of Credit are herein referred to as a "Letter of Credit"; the Bank and the issuer of any other Letter of Credit are herein referred to as a "Letter of Credit Provider."

In the case of a drawing to pay the principal or the purchase price of the Series 2011 Bonds of a Series, the stated amount of the Letter of Credit will be reduced by the principal amount of such drawing plus a corresponding amount of the interest portion of the Letter of Credit. In the case of a drawing to pay principal of the Series 2011 Bonds of a Series, the stated amount of the Letter of Credit will be reduced to the extent of any such drawing thereunder. Reductions in the Letter of Credit resulting from a drawing to pay the purchase price of Series 2011 Bonds of a Series shall be reinstated upon receipt by the Trustee of remarketing proceeds or other funds sufficient to reimburse the Bank for such drawing. Drawings to pay interest on the Series 2011 Bonds on an Interest Payment Date shall be automatically reinstated in an amount equal to the amount of such drawing following the honoring of such drawing.

Trustee Draws on Letters of Credit

The Indentures provide that, while any Letter of Credit is in effect, the Trustee shall draw moneys under such Letter of Credit in the following circumstances:

(i) on or before 4:00 p.m., New York City time, on the Business Day prior to any date any payment referred to in this paragraph is required to be made under the Indenture, the Trustee shall, without making any prior demand or claim upon the Alliance, make a drawing under and in accordance with the Letter of Credit so as to receive moneys thereunder on the next Business Day in an amount which will be sufficient for the payment in full of (i) accrued interest on the Series 2011 Bonds on any Interest Payment Date, (ii) the principal of and accrued interest on the Series 2011 Bonds upon the Stated Maturity of the Series 2011 Bonds, and (iii) the principal of and accrued interest on the Series 2011 Bonds upon the redemption of the Series 2011 Bonds.

(ii) on or before 11:30 a.m., New York City time, on the Business Day any payment referred to in this paragraph is required to be made under the Indenture, the Trustee shall, without making any prior demand or claim upon the Alliance, make a drawing under and in accordance with the Letter of Credit so as to receive moneys thereunder on such Business Day in an amount which will be sufficient, together with any proceeds of the remarketing of the Series 2011 Bonds by the Remarketing Agent then in the Bond Purchase Fund and available for application to the Series 2011 Bonds, for the payment in full of the purchase price (including, if applicable, accrued interest due in connection with a purchase on a Mandatory Tender Date or an Optional Tender Date, as the case may be) of all Series 2011 Bonds to be purchased under the terms of the Indenture.

(iii) on or before 4:00 p.m., New York City time, on the Business Day prior to the payment date of the Series 2011 Bonds upon acceleration of the Series 2011 Bonds after an event of default under the Indenture, the Trustee shall, without making any prior demand or claim upon the Alliance, make a drawing under and in accordance with the Letter of Credit so as to receive moneys thereunder in an amount which will be sufficient for the payment in full of the principal of and interest due on the Series 2011 Bonds on such payment date.

The Alliance has agreed pursuant to the Reimbursement Agreement to reimburse the Bank for amounts paid under and otherwise owing with respect to the Letters of Credit.

Extensions of Letter of Credit and Substitute Letter of Credit

Pursuant to the Loan Agreement for each Series of Series 2011 Tax-Exempt Bonds, and pursuant to the Thirtieth Supplement for the Series 2011 Taxable Bonds, the Alliance is required to maintain with the Trustee during the Weekly Rate Periods a Letter of Credit in an amount at least equal to the aggregate principal amount of Series 2011 Bonds then Outstanding plus 37 days' interest thereon. Prior to the expiration of a Letter of Credit, the Alliance shall deliver to the Trustee a Substitute Letter of Credit or cause an extension of such Letter of Credit. The extension of a Letter of Credit may be effected by the Bank's allowance of the Letter of Credit to renew automatically, delivery of an amendment to the Letter of Credit or by the delivery of a new Letter of Credit in the same form as the expiring Letter of Credit with an extended expiration date. The Alliance may also deliver a Substitute Letter of Credit to the Trustee at any time prior to the Conversion Date in the manner described below.

The Series 2011 Bonds shall be subject to mandatory tender for purchase on any Substitution Tender Date. A Substitute Letter of Credit must be an irrevocable letter of credit, having a term of at least one year, issued by a commercial bank organized or doing business in the United States, the terms of which shall in all material respects be the same as the initial Letter of Credit. Pursuant to the Indenture, the Trustee shall accept a Substitute Letter of Credit and surrender the previously held Letter of Credit if the Trustee receives (a) the Substitute Letter of Credit, (b) an Opinion of Counsel to the effect that the Substitute Letter of Credit has been duly authorized, executed and delivered by the issuer thereof and is a valid and binding obligation of the issuer thereof and (c) in the case of a Series of Series 2011 Tax-Exempt Bonds, an Opinion of Bond Counsel that the delivery of such Substitute Letter of Credit will not adversely affect the exclusion from gross income of interest on such Series of Series 2011 Tax-Exempt Bonds for federal income tax purposes. Upon the date the Trustee is permitted to draw under such Substitute Letter of Credit, the Trustee shall promptly surrender the previously held Letter of Credit to the issuer thereof for cancellation. At least 40 days prior to the effective date of such substitution, the Alliance is required to give the Trustee notice of such proposed substitution, and at least 30 days prior to the effective date of such substitution the Trustee will mail notice of such proposed substitution to the holders of all Series 2011 Bonds, advising them of the identity of the Bank giving the Substitute Letter of Credit.

THE BANKS

The timely payment of the principal of and interest on the Series 2011A Bonds and the Series 2011C Bonds and the purchase price thereof will be secured by irrevocable transferable direct-pay letters of credit issued by U.S. Bank National Association. For information on U.S. Bank National Association, see Appendix G-3.

The timely payment of the principal of and interest on the Series 2011B Bonds and the purchase price thereof will be secured by an irrevocable transferable direct-pay letter of credit issued by PNC Bank, National Association. For information on PNC Bank, National Association, see Appendix G-2.

The timely payment of the principal of and interest on the Series 2011D Bonds and the Series 2011 Taxable Bonds and the purchase price thereof will be secured by an irrevocable transferable direct-pay letter of credit issued by Mizuho Corporate Bank, Ltd. For information on Mizuho Corporate Bank, Ltd., see Appendix G-1.

INTEREST RATE SWAPS

The Alliance has various interest rate swaps and related derivatives currently in place, as described in Appendix A. Some of the existing arrangements have been entered into with affiliates of the Underwriters. The Alliance may in the future enter into swap agreements with respect to some or all of its obligations issued under the Master Indenture. See "MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE − Interest Rate Swaps and Derivatives" in Appendix A.

CERTAIN RISK FACTORS

The purchase of the Series 2011 Bonds involves certain risks that are discussed throughout this Official Statement. Each prospective purchaser of the Series 2011 Bonds should make an independent evaluation of all of the information presented in this Official Statement in order to make an informed investment decision. Certain of these risks are described below.

General

The ability of the Obligated Group to make payments on the Series 2011 Bonds is dependent upon the ability of the Members thereof to generate revenue sufficient to cover collective operating expenses and debt service on the Series 2011 Bonds and other indebtedness of the Obligated Group. Health care providers, especially hospitals, face increasing economic pressures from both governmental health care programs and private purchasers of health care such as insurance companies and health maintenance organizations (collectively, "third-party payors"). The dependence of hospitals on governmental programs requires hospitals to accept both limitations on payments and regulations and other restrictions and requirements triggered by participation in such programs. Many

governmental and private third-party payors have required healthcare providers to accept "capitated" or other fixed payments, which have the affect of shifting significant economic risk to healthcare providers.

Health care, especially at the hospital level, is a highly regulated industry with complicated and frequently changing regulations arising both from payment programs and governmental police power generally. Health care providers are increasingly subject to audits, investigations, fines and litigation that may threaten access to governmental reimbursement programs, require substantial payments, generate adverse publicity and create significant legal and other transaction costs. See below "Health Care Revenues." In addition, because the Alliance and a number of its affiliates are tax-exempt charitable organizations under the Internal Revenue Code ("Exempt Organizations"), they are subject to increasing regulation and restrictions that may have adverse effects on their economic performance or threaten their tax-exempt status and the economic benefits derived from it. In particular, such regulations and restrictions may require the facilities of the Alliance or such affiliates to provide health care services for which they do not receive payment. In addition, Congress is likely to consider imposing additional regulations and restrictions on Exempt Organizations.

Future economic and other conditions, including inflation, demand for health care services, the ability of the Alliance and other members of the Obligated Group to provide the services required or requested by patients, physicians' confidence in the Alliance, economic developments in the applicable service areas, employee relations and unionization, competition, the level of rates or charges, increased costs, availability of professional liability insurance, casualty losses, third-party reimbursement and changes in governmental regulation may adversely affect revenues and, consequently, the ability of the Alliance and other members of the Obligated Group to generate revenues sufficient for the payment of the principal of and interest on the Series 2011 Obligations.

Certain more specific factors that could affect the Series 2011 Bonds and the future financial condition of the Alliance and any future members of the Obligated Group are described below. This discussion of risk factors is not intended to be exhaustive.

Discretion of the Board and Management

The Master Indenture does not significantly restrict the ability of the Alliance to enter into transactions that could materially affect the business, organizational structure and control of the Alliance and any future members of the Obligated Group. Such transactions could include, for example, such things as divestitures of Affiliates, substantial new joint ventures, and mergers, consolidations or other forms of affiliations in which control of the Alliance and any future members of the Obligated Group could be materially changed. As a substantial health system, the Alliance regularly considers and analyzes opportunities for such undertakings. The ability of the Alliance to generate revenues sufficient to pay debt service on the Series 2011 Obligations is dependent in large measure on the decisions of the Board of Directors and management of the Alliance with respect to such opportunities.

Voting Control Under Master Indenture

Certain amendments and waivers to the provisions of the Master Indenture may be made with the consent of the owners of 75% of the aggregate principal amount of the Master Obligations then outstanding. Certain other amendments may be made with the consent of the owners of two-thirds (2/3) in aggregate principal amount of Master Obligations related to bonds that are not the beneficiaries of certain municipal bond insurance policies and the consent of the provider of certain municipal bond insurance policies. Such amendments may adversely affect the security of the holders of the Series 2011 Bonds.

For a discussion of what actions may be taken with the consent or direction of a majority percent or more of the holders of outstanding Master Obligations under the Master Indenture, see the discussion under "SUMMARY OF THE FINANCING DOCUMENTS" in Appendix D.

Matters Relating to Enforceability of the Master Indenture

The practical realization of any rights upon any default under the Loan Agreements or under the Master Indenture may depend upon the exercise of various remedies specified in such instruments, as restricted by federal and state laws. The federal bankruptcy laws may adversely affect the ability of the Trustees and the owners of the Series 2011 Bonds to enforce their claims granted by the Bond Indentures, the Loan Agreements or the Master Indenture. The obligation of the Alliance on the Series 2011 Obligations and other Master Obligations will be limited to the same extent as the obligations of debtors typically are affected by bankruptcy, reorganization, insolvency, fraudulent conveyance, moratorium or other similar laws affecting the enforcement of creditors' rights and by the availability of equitable remedies.

The remedies available to the Bond Trustees, the Master Trustee, the Issuers or the owners of the Series 2011 Bonds upon an event of default under the Master Indenture, the Bond Indentures, the Loan Agreements or the Series 2011 Obligations are in many respects dependent upon judicial actions, which are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including, specifically, Title 11 of the United States Code (the "Bankruptcy Code"), the remedies provided in the Master Indenture, the Bond Indentures, the Loan Agreements and the Series 2011 Obligations and other Master Obligations may not be readily available or may be limited.

There is no clear precedent in the law as to whether transfers from an Affiliate in order to pay debt service on the Master Obligations issued for the benefit of another Affiliate may be voided by a trustee in bankruptcy in the event of a bankruptcy of the transferring Affiliate or by third-party creditors in an action brought pursuant to state fraudulent conveyances statutes. Under the United States Bankruptcy Code, a trustee in bankruptcy and, under state fraudulent conveyances statutes, a creditor of a related guarantor, may avoid any obligation incurred by a related guarantor, if, among other bases therefor, (i) the guarantor has not received fair consideration or reasonably equivalent value in exchange for the guaranty and (ii) the guaranty renders the guarantor insolvent, as defined in the United States Bankruptcy Code or state fraudulent conveyances statutes, or the guarantor is undercapitalized.

Limited Value at Foreclosure

The Mortgaged Property was constructed for the provision of hospital care. The number of entities that could be expected to purchase or lease the Mortgaged Property are limited, and thus, the ability of the Master Trustee to realize funds from the sale or rental of the Mortgaged Property upon an event of default may be limited.

Bond Ratings

There is no assurance that the ratings assigned to the Series 2011 Bonds will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for and marketability of the Series 2011 Bonds. See the information in "RATINGS."

Market for the Series 2011 Bonds

The relative buying and selling interest of market participants in securities such as the Series 2011 Bonds, and in the market for such securities as a whole, will vary over time, and such variations may be affected by, among other things, news relating to the Alliance and the other Obligated Issuers, the attractiveness of alternative investments, the perceived risk of owning the security (whether related to credit, liquidity or any other risk), the tax treatment accorded the instruments, the accounting treatment accorded such securities, reactions to regulatory actions or press reports, financial reporting cycles and marketing sentiment generally. Shifts of demand in response to any one or simultaneous particular events cannot be predicted and may be short-lived or exist for longer periods. See below "Tax Matters."

Health Care Revenues

There are a number of factors that could adversely affect both revenues and expenses of the Alliance. Some but not all such factors are discussed briefly below. Governmental payment provisions, regulations and other restrictions change frequently and may be altered or expanded while the Series 2011 Bonds are outstanding.

Dependence on Governmental and Other Third-Party Payors. The Alliance receives a substantial portion of its revenues from Medicare, Medicaid, TennCare and other third-party health care programs. See in Appendix A - "SOURCES OF REVENUE." Receipt of such revenues subjects the Alliance to extensive regulation and the risks of enforcement as described below. Both governmental payment programs and private third-party payors such as insurance and managed care programs have increasingly imposed limitations on the payment for services. These limitations often require hospitals to provide certain services below cost. Congress in the past has imposed substantial restrictions on federal health care programs that have adversely affected the financial condition of hospitals, and it may do so in the future.

TennCare. In 1994, the State of Tennessee, with the approval of the federal government, withdrew from the Medicaid program and began providing services to Medicaid eligible and uninsurable or uninsured persons through TennCare. Like traditional Medicaid programs, TennCare is funded with a combination of federal and State of Tennessee funds. The federal government has approved the TennCare Program through June 30, 2010. The Alliance is a significant provider of health care services to TennCare enrollees and as a result thereof has incurred substantial losses serving beneficiaries of the program. Approximately 8.3% of the Alliance's gross patient service charges for the fiscal year ended June 30, 2011, was derived from patients covered by TennCare.

Because of problems with managed care organizations through which TennCare operates, the State assumed total medical risk for the program in 2002 and implemented changes designed to reduce costs and fraud. The State of Tennessee initiated a plan to disenroll 323,000 individuals statewide from TennCare and to institute significant benefit cuts resulting in the disenrollment of 28,000 individuals in the Alliance's market and a decrease in the level of benefits for 40,000 individuals in the Alliance's market. The disenrollment changes took place on August 1, 2005, however, the benefit cuts have not been implemented.

On April 1, 2007, the State of Tennessee began placing the managed care organizations back at risk, starting with the Middle Tennessee Region. The State of Tennessee placed the East Tennessee Region's managed care organizations (where the Alliance operates its Tennessee facilities) back at risk on January 1, 2009. It cannot be predicted whether the funding sources for TennCare or other states' Medicaid programs will be adequate to meet the funding needs of such programs. In addition, it cannot be predicted whether funding pressures or other factors will lead to decreased TennCare and Medicaid reimbursement to providers, including the Members of the Obligated Group, or to an increase in uninsured patients seeking care from the Members of the Obligated Group.

A number of proposals have been made for changes in funding for TennCare, some of which could substantially reduce the amounts payable to the Alliance's facilities in Tennessee. There remains substantial risk that TennCare will continue to impose substantial financial burdens on the Alliance or that changes in the program could lead to further burdens or increase the cost of uncompensated care provided by the Alliance.

Virginia Medicaid Program. The hospitals of the Alliance located in Virginia receive a substantial portion of their revenues under the federal Medicare Program. Reimbursement under this program is controlled by extensive regulations and procedures. Under the current Medicare payment system payment for inpatient hospital services is been tied to predetermined amounts based on national averages of costs for categories of treatments and conditions known as diagnosis related groups ("DRGs"). DRG reimbursement may provide a hospital less than its actual costs in providing services. The Medicare Program reimburses for outpatient hospital services through a similar prospective payment system based on ambulatory payment classifications ("APCs") of clinically-related and resource-similar items and services. Reimbursement for outpatient services under the APC system and for other services provided by the hospitals of the Alliance may not reflect the actual costs incurred in providing such services or items.

Medicare reimbursement in recent years has been subject to changes that have adversely affected hospitals, and the Alliance cannot predict how future limitations, cutbacks or modifications by Congress or regulatory agencies to such reimbursement may affect the financial condition of the Alliance.

Hospital Regulation. The operation of hospitals is extensively regulated by the federal and state governments. These regulations affect virtually every aspect of hospital operations, including (1) imposing procedures that increase costs (including complicated billing and other record-keeping procedures), (2) requiring the provision of services free or below cost, (3) limiting the ability to make decisions based on economic best interest and (4) restricting the ability to pursue advantageous business opportunities with physicians and other health care providers.

Significant restrictions include (1) the Physicians Self-Referral ("Stark") and "Anti-Kickback" laws, which severely restrict financial relationships with and referrals by private physicians; (2) the Emergency Medical Treatment and Active Labor Act ("EMTALA"), imposing operating requirements on emergency rooms; and (3) the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act of 2009 and both affecting the privacy and security of personal health information. Compliance with HIPAA, HITECH and related regulations has imposed substantial financial burdens on the Alliance and related entities in such areas as electronic billing and other electronic transactions and in implementing procedures and altering facilities to promote privacy of patient records.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate violations of existing laws and regulations, including criminal fines, civil monetary penalties, repayment of erroneously paid claims, prison terms and exclusion from the Medicare, Medicaid, TennCare and/or other governmental payment programs. Because of the complexity of the regulations and the increased enforcement, there are numerous circumstances where alleged violations may trigger investigations, audits and inquiries that could result in expensive and prolonged enforcement actions against the Alliance. Enforcement actions may be initiated and prosecuted by one or more government entities and/or private individuals, and in some circumstances more than one of the available penalties may be imposed for each violation. An exclusion from participation in Medicare, Medicaid, TennCare or other governmental health programs likely would result in a loss of substantial revenues.

National Healthcare Reform

Comprehensive health care reform legislation was enacted by the federal government in March 2010 through the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the "Healthcare Reform Act"). The Healthcare Reform Act provides for fundamental changes to the health care system and the manner in which services are provided and paid for generally, including substantial increases in health care insurance for persons not currently covered, new requirements on employers who provide health benefits to their employees, reimbursement reductions and methodology changes, and the imposition of further restrictions and requirements adversely affecting tax-exempt hospitals such as the Alliance and its related entities.

Implementation of the Healthcare Reform Act is to take place over an eight year time horizon, and over that time the Healthcare Reform Act is likely to have a variety of effects on both the operations and financial performance of all hospitals. In particular, extension of health insurance to those not currently insured and the costs associated therewith may result in (1) inadequate reimbursement to cover costs under such new coverage, (2) offsetting reductions in reimbursements for the provision of services under Medicare, Medicaid and other federally funded programs and (3) increased costs of compliance generally. In addition to its direct effects on the Alliance and related hospitals, the Healthcare Reform Act is likely to have significant indirect effects on the Alliance and related hospitals as a result of the Act's effects on other healthcare industry participants, including pharmaceutical and medical device companies, health insurers, and others with which the Alliance and related hospitals do business.

The Healthcare Reform Act imposes substantial and costly additional requirements on nonprofit hospitals. Failure of any hospital with 501(c)(3) status to comply with such requirements will result in significant penalties

including, but not limited to, the loss of tax-exempt status. See below "Tax Matters − Tax Exemption for Non-profit Corporations."

The future of the Healthcare Reform Act is uncertain. The Healthcare Reform Act has been subject to numerous legal challenges in federal court, some but not all of which have been successful at the District Court and the Court of Appeals levels. Moreover, the 2010 Congressional elections, which resulted in a Republican majority in the U.S. House of Representatives, have resulted in legislative efforts to repeal the Healthcare Reform Act, to amend or defund it, or otherwise to block its implementation.

Thus, it is impossible to predict the extent to which the Healthcare Reform Act will be implemented or the effects the Healthcare Reform Act will have to the extent it is implemented. The current uncertainties are likely to continue at least until the 2012 elections and the final resolution of the constitutional challenges to the Healthcare Reform Act by the United States Supreme Court.

Competition. The Alliance faces competition not only from other area hospitals (see in Appendix A -"SERVICE AREA, MARKET SHARE AND COMPETITION"), but also from other forms of health care providers, including health maintenance organizations, preferred provider organizations, specialty hospitals, home health agencies, surgical centers, rehabilitation and therapy centers, physician group practices and other alternative delivery systems and non-hospital providers of medical services. Increasing costs of health care services are likely to stimulate additional forms of competition. Many new forms of health care providers may not be subject to the restrictions imposed on the Alliance by its participation in governmental health care programs and as part of a tax-exempt organization. The application of federal and state antitrust laws to health care is still evolving, and enforcement and other developments in this area could adversely affect the Alliance's competitive position.

Other Economic Developments. Other economic developments that could adversely affect operations at the Alliance include (1) unexpected increases in costs of labor and equipment (including new technologies) that cannot be recovered through charges, (2) increased costs of maintaining malpractice and general liability insurance, and (3) availability of, or the cost of, required specialty employees, including nurses and other health care professionals.

Tax Matters

Tax Exemption for Non-profit Corporations

Loss of tax-exempt status by the Alliance could result in loss of tax exemption for interest on the Series 2011 Bonds and of other tax-exempt debt issued for the benefit of the Alliance, and defaults in covenants regarding the Series 2011 Bonds and other tax-exempt debt would likely be triggered. Such an event would have material adverse consequences on the financial condition of the Alliance.

The maintenance by the Alliance of its tax-exempt status and that of its related entities depends, in part, upon its maintenance of status as an organization (an "Exempt Organization") described in Section 501(c)(3) of the Code. The maintenance of such status is contingent upon compliance with provisions of the Code and related regulations and administrative interpretations regarding the organization and operation of tax-exempt entities, including its operation for charitable and educational purposes and its avoidance of transactions that may cause its assets to inure to the benefit of private individuals.

The Internal Revenue Service (the "IRS") has announced that it intends to closely scrutinize transactions between Exempt Organizations and for-profit entities and has issued audit guidelines for tax-exempt hospitals. In March 1998, the IRS issued a revenue ruling that places restrictions upon the participation of Exempt Organizations (including hospitals) in joint venture arrangements with for-profit entities. Although specific activities of hospitals, such as medical office building leases and compensation arrangements and other contracts with physicians, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities have not been addressed in any official opinion, interpretation or policy of the IRS. Because the Alliance conducts large-scale and diverse operations involving private parties, there can be no assurances that certain of its transactions would not be challenged by the IRS.

The IRS has taken the position that hospitals that violate the federal Anti-kickback Law may also be subject to revocation of their tax-exempt status. As a result, tax-exempt hospitals, such as those of the Alliance, which have and will continue to have, extensive transactions with physicians are subject to an increased degree of scrutiny and perhaps enforcement by the IRS.

Periodically, Congress considers options and recommendations in the area of taxation of unrelated business income of Exempt Organizations. The scope and effect of legislation, if any, that may be adopted at the federal and state levels with respect to unrelated business income cannot be predicted at this time. However, any such legislation could have the effect of subjecting a portion of the income of the Alliance to federal or state income taxes.

In addition to the foregoing proposals with respect to income by Exempt Organizations, various state and local governmental bodies have challenged the tax-exempt status of such institutions and have sought to remove the exemption of property from real estate taxes of part or all of the property of various nonprofit institutions on the grounds that a portion of such property was not being used to further the charitable purposes of the institutions or that the institutions did not provide sufficient care to indigent persons so as to warrant exemption from taxation as a charitable institution. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of Exempt Organizations. There can be no assurance that future changes in the laws and regulations of federal, state or local governments, or the interpretation of such laws by courts or other governmental entities, will not materially adversely affect the operations and financial condition of the Alliance by requiring any of its entities to pay income or local property taxes.

Tax-Exempt Status of the Series 2011 Tax-Exempt Bonds

Any failure by the Alliance or related entities to remain qualified as tax-exempt under Section 501(c)(3) of the Code could affect the amount of funds that would be available to pay debt service on the Series 2011 Bonds. If the Alliance or the respective Issuer fails to comply continuously with certain covenants contained in the Bond Indentures and the Loan Agreements after delivery of the Series 2011 Tax-Exempt Bonds, interest on the Series 2011 Tax-Exempt Bonds could become taxable from the date of delivery of the Series 2011 Tax-Exempt Bonds regardless of the date on which the event causing such taxability occurs.

In recent years, the IRS has undertaken an extensive audit program that involves review of both the general tax-exempt status of non-profit hospitals and the tax-exempt status of bonds issued for their benefit.

Legislative Proposals

Current and future legislative proposals, if enacted into law, could cause interest on the Series 2011 Tax-Exempt Bonds to be subject, directly or indirectly, to federal income taxation or otherwise prevent owners thereof from realizing the full current benefit of the tax-exempt status of such interest. On September 12, 2011, the Obama Administration announced a legislative proposal, the "American Jobs Act of 2011," (the "Jobs Act"). If enacted in the form proposed, the Jobs Act would limit the exclusion from gross income of interest on obligations like the Series 2011 Tax-Exempt Bonds for individual taxpayers whose income is subject to higher marginal tax rates. The enactment of the Jobs Bill or similar provisions could adversely affect the tax treatment of interest on the Series 2011 Tax-Exempt Bonds for holders thereof and adversely affect the market price of the Series 2011 Tax-Exempt Bonds.

Other Risk Factors Generally Affecting Health Care Facilities

In the future, the following factors, among others, may adversely affect the operations of the Alliance to an extent that cannot be determined at this time:

1. Health care systems are major employers, combining a complex mix of professional, quasi-professional, technical, clerical, housekeeping, maintenance, dietary and other types of workers in a single

operation. As with all large employers, the Alliance bears a wide variety of risks in connection with its employees. These risks include strikes and other related work actions, contract disputes, discrimination claims, personal tort actions, work-related injuries, exposure to hazardous materials, interpersonal torts (such as between employees, between physicians or management and employees, or between employees and patients), and other risks that may flow from the relationships between employer and employee or between physicians, patients and employees. Many of these risks are not covered by insurance, and certain of them cannot be anticipated or prevented in advance. The Alliance is subject to all of the risks listed above. Such risks, alone or in combination, could have material adverse consequences to the financial condition or operations of the Alliances.

2. Competition from other health care systems and other competitive facilities now or hereafter located in the respective service areas of the Alliance's facilities may adversely affect revenues. Development of health maintenance and other alternative health delivery programs could result in decreased usage of inpatient hospital facilities and other facilities operated by the Alliance.

3. Cost and availability of any insurance, such as malpractice, fire, automobile, and general comprehensive liability, that hospitals and other health care facilities of similar size and type as the facilities generally carry may adversely affect revenues, as would any losses that exceed amounts covered.

4. The occurrences of natural disasters may damage some or all of the facilities, interrupt utility service to some or all of the facilities, significantly increase the demand on some or all of the facilities or otherwise impair the operation of some or all of the facilities or the generation of revenues from some or all of the facilities.

5. Scientific and technological advances, new procedures, drugs and appliances, preventive medicine, occupational health and safety and outpatient health care delivery may reduce utilization and revenues of the facilities. Technological advances in recent years have accelerated the trend toward the use by hospitals of sophisticated and costly equipment and services for diagnosis and treatment. The acquisition and operation of certain equipment or services may continue to be a significant factor in hospital utilization, but the ability of the Alliance to offer such equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance such acquisitions or operations.

6. Reduced demand for the services of the Alliance that might result from decreases in population in the services areas of facilities operated by the Alliance.

7. Increased unemployment or other adverse economic conditions in the service areas of the Alliance that would increase the proportion of patients who are unable to pay fully for the cost of their care.

8. Any increase in the quantity or cost of indigent care provided that is mandated by law or required due to increase needs of the community in order to maintain the charitable status of the Alliance.

9. Regulatory actions that might limit the ability of the Alliance to undertake capital improvements to their respective facilities or to develop new institutional health services.

LITIGATION

There is no action, suit, or proceeding pending or, to the knowledge of the Issuers, threatened restraining or enjoining the execution or delivery of the Series 2011 Bonds, or in any way contesting or affecting the validity of the Series 2011 Bonds, the Bond Indentures, the Master Indenture, or any proceedings of the Issuers or the Alliance, as applicable, taken with respect thereto. No securities of any Issuer have been in default as to principal or interest payments or in any other material respect, and no agreements or legal proceedings of any Issuer relating to its securities have been declared invalid or unenforceable since the formation of each Issuer. Each Issuer will provide a certificate to this effect at the time of delivery of the Series 2011 Bonds.

There is no action, suit, or proceeding pending or threatened restraining or enjoining the execution or delivery of the Series 2011 Obligations, or in any way contesting or affecting the validity of the Series 2011 Obligations, the Master Indenture, the Loan Agreements or any proceedings of the Alliance taken with respect thereto. No securities of the Alliance have been in default as to principal or interest payments or in any other material respect, and no agreements or legal proceedings of the Alliance relating to its securities have been declared

invalid or unenforceable since the original formation of the corporation now called Mountain States Health Alliance. The Alliance will provide a certificate to this effect at the time of delivery of the Series 2011 Bonds.

For other litigation matters involving the Alliance, see "HISTORY AND OVERVIEW - Insurance; Litigation" in Appendix A hereto.

LEGAL MATTERS

Legal matters relating to the authorization and issuance of the Series 2011 Tax-Exempt Bonds are subject to the approving opinion of Bass, Berry & Sims PLC of Nashville and Knoxville, Tennessee, as Bond Counsel, which will be delivered with the Series 2011 Bonds. Bond Counsel's opinion with respect to the Series 2011 Virginia Bonds is being given in reliance on the opinion of Hunton & Williams LLP with respect to certain matters of Virginia law. Certain legal matters relating to the Series 2011 Bonds will also be passed upon by Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Tennessee Issuer, by Gwyn & Tate, Marion, Virginia, as counsel to the Virginia Issuer, and by Anderson, Fugate & Givens, Johnson City, Tennessee, as counsel to the Alliance. Certain legal matters will be passed upon by Thompson Coburn LLP, St. Louis, Missouri, as counsel to the Banks. Certain legal matters will be passed upon by Hunton & Williams LLP, as counsel to the Underwriters.

TAX MATTERS

Tennessee State Tax Exemption

Under existing law, the Series 2011 Tennessee Bonds and the income therefrom are exempt from all present state, county and municipal taxes in Tennessee except (a) inheritance, transfer and estate taxes, (b) Tennessee excise taxes on interest on the Series 2011 Tennessee Bonds during the period the Series 2011 Tennessee Bonds are held or beneficially owned by any organization or entity, other than a sole proprietorship or general partnership doing business in the State, and (c) Tennessee franchise taxes by reason of the inclusion of the book value of the Series 2011 Tennessee Bonds in the Tennessee franchise tax base of any organization or entity, other than a sole proprietorship or general partnership, doing business in the State.

Virginia State Tax Exemption

In the opinion of Bond Counsel, under current law, interest on the Series 2011 Virginia Bonds is exempt from income taxation by the Commonwealth of Virginia.

Series 2011 Tax-Exempt Bonds

General. Bass, Berry & Sims PLC, Nashville, Tennessee, is Bond Counsel for the Series 2011 Tax-Exempt Bonds. Bond Counsel is the opinion that, under existing law, relying on certain statements by the Alliance and assuming compliance by the Alliance with certain covenants, interest on the Series 2011 Tax-Exempt Bonds is:

- an S corporation,
- not a preference item for a bondholder under the federal alternative minimum tax; but
- however, taken into account in determining the adjusted current earnings of certain corporations for purposes of the federal corporate alternative minimum tax.

The Code imposes requirements on the Series 2011 Tax-Exempt Bonds that the Alliance must continue to meet after the Series 2011 Tax-Exempt Bonds are issued. These requirements generally involve the way that Series 2011 Tax-Exempt Bond proceeds must be invested and ultimately used. If the Alliance does not meet these requirements, it is possible that a bondholder may have to include interest on the Series 2011 Tax-Exempt Bonds in its federal gross income on a retroactive basis to the date of issue. The Alliance has covenanted to do everything necessary to meet these requirements of the Code.

A bondholder who is a particular kind of taxpayer may also have additional tax consequences from owning the Series 2011 Tax-Exempt Bonds. This is possible if a bondholder is:

- an S corporation,
- a United States branch of a foreign corporation,
- a financial institution,
- a property and casualty or a life insurance company,
- an individual receiving Social Security or railroad retirement benefits,
- an individual claiming the earned income credit, or
- a borrower of money to purchase or carry the Series 2011 Tax-Exempt Bonds.

If a bondholder is in any of these categories, it should consult its tax advisor.

Bond Counsel is not responsible for updating its opinion in the future. It is possible that future events or changes in applicable law could change the tax treatment of the interest on the Series 2011 Tax-Exempt Bonds or affect the market price of the Series 2011 Tax-Exempt Bonds.

Bond Counsel expresses no opinion on the effect of any action taken or not taken in reliance upon an opinion of other counsel on the federal income tax treatment of interest on the Series 2011 Tax-Exempt Bonds, or under state, local or foreign tax law.

Possible Legislative Changes. Certain recent legislative proposals, if enacted, could adversely affect both the market value of the Series 2011 Tax-Exempt Bonds and the treatment of interest thereon for holders of the Series 2011 Tax-Exempt Bonds. See above "CERTAIN RISK FACTORS − Tax Matters − Legislative Proposals."

Series 2011 Taxable Bonds

***Disclaimer*. Any discussion of the tax issues relating to the Series 2011 Taxable Bonds in this Official Statement was written to support the promotion or marketing of the Series 2011 Taxable Bonds. Such discussion was not intended or written to be used, and it cannot be used, by any person for the purpose of avoiding any tax penalties that may be imposed on such person. Each investor should seek advice with respect to the Series 2011 Taxable Bonds based on its particular circumstances from an independent tax advisor.**

General. The following is a summary of certain anticipated United States federal income tax consequences of the purchase, ownership and disposition of the Series 2011 Taxable Bonds. The summary is based upon the provisions of the Code, the regulations promulgated thereunder and the judicial and administrative rulings and decisions now in effect, all of which are subject to change. The summary generally addresses Series 2011 Taxable Bonds held as capital assets and does not purport to address all aspects of federal income taxation that may affect particular investors in light of their individual circumstances or certain types of investors subject to special treatment under the federal income tax laws, including but not limited to financial institutions, insurance companies, dealers in securities or currencies, those holding such bonds as hedge against currency risks or as a position in a "straddle" for tax purposes, or those whose functional currency is not the United States dollar. Potential purchasers of the Series 2011 Taxable Bonds should consult their own tax advisors in determining the federal, state or local consequences to them of the purchase, ownership and disposition of the Series 2011 Taxable Bonds.

Interest on the Series 2011 Taxable Bonds is not excluded from gross income for federal income tax purposes. Purchasers other than those who purchase Series 2011 Taxable Bonds in the initial offering at their stated principal amounts will be subject to federal income tax accounting rules affecting the timing and/or characterization of payments received with respect to such Series 2011 Taxable Bonds. In general, interest paid on the Series 2011 Taxable Bonds and accrual of market discount, if any, will be treated as ordinary income to an owner of Series 2011 Taxable Bonds and, after adjustment for the foregoing, principal payments will be treated as a return of capital.

Market Discount. Any owner who purchases a Series 2011 Taxable Bond at a price which includes market discount in excess of a prescribed de minimis amount (*i.e.*, at a purchase price that is less than its adjusted issue price in the hands of an original owner) will be required to recharacterize all or a portion of the gain as ordinary income upon receipt of each scheduled or unscheduled principal payment or upon other disposition. In particular, such owner will generally be required either (a) to allocate each such principal payment to accrued market discount

not previously included in income and to recognize ordinary income to that extent and to treat any gain upon sale or other disposition of such a Series 2011 Taxable Bond as ordinary income to the extent of any remaining accrued market discount (under this caption) or (b) to elect to include such market discount in income currently as it accrues on all market discount instruments acquired by such owner on or after the first day of the taxable year to which such election applies.

The Code authorizes the Treasury Department to issue regulations providing for the method for accruing market discount on debt instruments the principal of which is payable in more than one installment. Until such time as regulations are issued by the Treasury Department, certain rules described in the legislative history of the Tax Reform Act of 1986 will apply. Under those rules, market discount will be included in income either (a) on a constant interest basis or (b) in proportion to the accrual of stated interest.

An owner who acquires a Series 2011 Taxable Bond at a market discount also may be required to defer, until the maturity date of such Series 2011 Taxable Bond or the earlier disposition in a taxable transaction, the deduction of a portion of the amount of interest that the owner paid or accrued during the taxable year on indebtedness incurred or maintained to purchase or carry a Series 2011 Taxable Bond in excess of the aggregate amount of interest (including original issue discount) includable in such owner's gross income for the taxable year with respect to such Series 2011 Taxable Bond. The amount of such net interest expense deferred in a taxable year may not exceed the amount of market discount accrued on the Series 2011 Taxable Bonds for the days during the taxable year on which the owner held the Series 2011 Taxable Bond and, in general, would be deductible when such market discount is includable in income. The amount of any remaining deferred deduction is to be taken into account in the taxable year in which the Series 2011 Taxable Bond matures or is disposed of in a taxable transaction. In the case of a disposition in which gain or loss is not recognized in whole or in part, any remaining deferred deduction will be allowed to the extent gain is recognized on the disposition. This deferral does not apply if the bondowner elects to include such market discount in income currently as described above.

Bond Premium. A purchaser who purchases a Series 2011 Taxable Bond at a cost greater than its then principal amount will have amortizable bond premium. If the holder elects to amortize the premium under Section 171 of the Code (which election will apply to all bonds held by the holder on the first day of the taxable year to which the election applies, and to all bonds thereafter acquired by the holder), such a purchaser must amortize the premium using constant yield principles based on the purchaser's yield to maturity. Amortizable bond premium is generally treated as an offset to interest income, and a reduction in basis is required for amortizable bond premium that is applied to reduce interest payments. Purchasers of any Series 2011 Taxable Bonds who acquire such Series 2011 Taxable Bonds at a premium should consult with their own tax advisors with respect to the determination and treatment of such premium for federal income tax purposes and with respect to state and local tax consequences of owning such Series 2011 Taxable Bonds.

Sale or Redemption of Series 2011 Taxable Bonds. A bondowner's tax basis for a Series 2011 Taxable Bond is the price such owner pays for the Series 2011 Taxable Bond plus the amount of any original issue discount and market discount previously included in income, reduced on account of any payments received (other than "qualified stated interest" payments) and any amortized bond premium. Gain or loss recognized on a sale, exchange or redemption of a Series 2011 Taxable Bond, measured by the difference between the amount realized and the basis of the Series 2011 Taxable Bond as so adjusted, will generally give rise to capital gain or loss if the Series 2011 Taxable Bond is held as a capital asset (except as discussed above under "Market Discount"). The legal defeasance of Series 2011 Taxable Bonds may result in a deemed sale or exchange of such Series 2011 Taxable Bonds under certain circumstances; owners of such Series 2011 Taxable Bonds should consult their tax advisors as to the federal income tax consequences of such an event.

Backup Withholding. A bondowner may, under certain circumstances, be subject to "backup withholding" (currently the rate of this withholding obligation is 28%, but the rate may change in the future) with respect to interest or original issue discount on the Series 2011 Taxable Bonds. This withholding generally applies if the owner of a Series 2011 Taxable Bond (a) fails to furnish the Registration Agent or other payor with its taxpayer identification number; (b) furnishes the Registration Agent or other payor an incorrect taxpayer identification number; (c) fails to report properly interest, dividends or other "reportable payments" as defined in the Code; or (d) under certain circumstances, fails to provide the Registration Agent or other payor with certified statement, signed under penalty of perjury, that the taxpayer identification number provided is its correct number and that holder is not

subject to backup withholding. Backup withholding will not apply, however, with respect to certain payments made to bondowners, including payments to certain exempt recipients (such as certain exempt organizations) and to certain Nonresidents. Owners of the Series 2011 Taxable Bonds should consult their tax advisors as to their qualification for exemption from backup withholding and the procedure for obtaining the exemption.

Backup withholding is not an additional tax. Any amount paid as backup withholding would be credited against the bondholder's U.S. federal income tax liability, provided that the requisite information is timely provided to the Internal Revenue Service. The amount of "reportable payments" for each calendar year and the amount of tax withheld, if any, with respect to payments on the Series 2011 Taxable Bonds will be reported to the bondowners and to the Internal Revenue Service.

***Nonresident Borrowers*.** Under the Code, interest and original issue discount income with respect to Series 2011 Taxable Bonds held by nonresident alien individuals, foreign corporations or other non-United States persons ("Nonresidents") generally will not be subject to the United States withholding tax (or backup withholding) if the Borrower (or other who would otherwise be required to withhold tax from such payments) is provided with an appropriate statement that the beneficial owner of the Series 2011 Taxable Bond is a Nonresident. Notwithstanding the foregoing, if any such payments are effectively connected with a United States trade or business conducted by a Nonresident bondowner, they will be subject to regular United States income tax, but will ordinarily be exempt from United States withholding tax.

Interest on the Series 2011 Taxable Bonds is not tax-exempt under either federal or state law.

RATINGS

Moody's Investors Services, Inc. ("Moody's") and Standard & Poor's Rating Services, a division of The McGraw Hill Companies, Inc. ("S&P") have assigned the Series 2011A Bonds and the Series 2011C Bonds the respective ratings set forth below:

Moody's:	Aa2/VMIG1
Standard & Poor's:	AA-/A-1+

Moody's and S&P have assigned the Series 2011B Bonds the respective ratings set forth below:

Moody's:	A1/VMIG1
Standard & Poor's:	A+/A-1

Moody's and S&P have assigned the Series 2011D Bonds and the Series 2011E Bonds the respective ratings set forth below:

Moody's:	Aa3*/VMIG1
Standard & Poor's:	A+/A-1

* The long-term ratings of Series 2010D Bonds and the Series 2011E Bonds are on review for downgrade in connection with Moody's ongoing review of Mizuho Corporate Bank, Ltd.

Each such rating is based on the availability of the Letters of Credit and reflects only the views of the rating agency assigning such rating and an explanation of the significance of such rating should be obtained from the applicable rating agency itself. Certain materials and information relating to the Series 2011 Bonds, the Banks and the Alliance that may not be described in this Official Statement were furnished to the rating agencies in connection with the issuance of the ratings. Generally, rating agencies base their ratings on such materials and information and on their own investigations, studies and assumptions. There is no assurance that any rating will remain in effect for any given period of time or that any rating will not be lowered or withdrawn entirely if, in the judgment of the rating agency, circumstances so warrant.

No information is provided regarding the ratings of other outstanding bonds issued for the benefit of the Alliance and related entities.

UNDERWRITING

Merrill Lynch, Pierce, Fenner & Smith Incorporated ("Merrill Lynch") and U.S. Bank Municipal Securities Group, a division of U.S. Bank National Association ("US Bancorp" and, together with Merrill Lynch, the "Underwriters") have agreed to purchase (1) the Series 2011A Bonds at a price of $64,998,960, representing the par amount of the Series 2011A Bonds less an underwriters' discount of $261,040 (0.40% of the principal amount thereof); and (2) the Series 2011C Bonds at a price of $49,675,000, representing the par amount of the Series 2011C Bonds less an underwriters' discount of $199,500 (0.40% of the principal amount thereof). Merrill Lynch and U.S. Bancorp are committed to take and pay for all of the Series 2011A Bonds and the Series 2011C Bonds if any are taken.

Merrill Lynch has agreed to purchase (x) the Series 2011B Bonds at a price of $19,920,000, representing the par amount of the Series 2011B Bonds less an underwriters' discount of $80,000 (0.40% of the principal amount thereof); (y) the Series 2011D Bonds at a price of $60,462,180, representing the par amount of the Series 2011D Bonds less an underwriters' discount of $242,820 (0.40% of the principal amount thereof); and (z) the Series 2011 Taxable Bonds at a price of $15,896,160, representing the par amount of the Series 2011 Taxable Bonds less an underwriters' discount of $63,840 (0.40% of the principal amount thereof). Merrill Lynch is committed to take and pay for all of the Series 2011B Bonds, the Series 2011D Bonds and the Series 2011 Taxable Bonds if any are taken.

The prices at which the Series 2011 Bonds are offered to the public (and the yields resulting therefrom) may vary from the initial public offering prices. In addition, the Underwriters may allow commissions or discounts to dealers and others from the initial offering prices appearing on the cover page of this Official Statement. From time to time, the Underwriters may enter into other transactions with the Alliance, including interest rate swaps and options, for which it receives other compensation.

"US Bancorp" is the marketing name of U.S. Bancorp and its subsidiaries, including (1) U.S. Bank Municipal Securities Group, a division of U.S. Bank National Association ("USB MSG"), which is serving as Co-Manager of the Series 2011A Bonds and the Series 2011C Bonds, (2) U.S. Bancorp Investments, Inc. ("USBII"), which, along with USB MSG, is serving as Remarketing Agent for the Series 2011C Bonds, and (3) U.S. Bank National Association ("USBNA"), which is providing the Letter of Credit for the Series 2011A Bonds and the Series 2011C Bonds.

INDEPENDENT AUDITORS

The consolidated financial statements of the Alliance as of and for the years ended June 30, 2010 and 2009, included in Appendix B to this Official Statement, have been audited by Pershing Yoakley & Associates, P.C.

CONTINUING DISCLOSURE AGREEMENT

The Agreement

To permit compliance by the Underwriters with the continuing disclosure requirements of Rule 15c2-12 (the "Rule") promulgated by the Securities and Exchange Commission, the Alliance will execute a Continuing Disclosure Agreement (the "Continuing Disclosure Agreement") at closing pursuant to which the Alliance will agree to provide certain quarterly and annual financial information and material event notices required by the Rule. Such information will be filed through the Electronic Municipal Market Access System ("EMMA") maintained by the Municipal Securities Rulemaking Board and may be accessed through the Internet at emma.mrsb.org. The proposed form of the Continuing Disclosure Agreement is set forth in Appendix F. It requires the Alliance to provide **only limited information at specific times, and the information provided may not be all the information necessary to value the Series 2011 Bonds at any particular time.** The Alliance may from time to time disclose certain information and data in addition to that required by the Continuing Disclosure Agreement. If

the Alliance chooses to provide any additional information, the Alliance shall have no obligation to continue to update such information or to include it in any future disclosure filing.

Failure by the Alliance to comply with the Continuing Disclosure Agreement is not an Event of Default under the Loan Agreements. The Continuing Disclosure Agreement provides that the only remedy for its violation is a lawsuit seeking specific performance.

Prior Undertakings

In connection with the issuance of previous bonds, the Alliance has entered into continuing disclosure undertakings similar to the Continuing Disclosure Agreement. Prior to July 1, 2009, the Alliance's filings under such undertakings were made through the then existing national recognized municipal securities information repositories. Since then filings have been made through EMMA.

The Alliance failed to make certain filings previously scheduled under previous continuing disclosure undertakings. In November, 2008, the Alliance submitted Annual Financial Information for the fiscal years ended June 30, 2000 through June 30, 2008 and Quarterly Financial Information for the quarters ended March 31, 2000 through June 30, 2008. Such filings were not timely under the Alliance's existing continuing disclosure undertakings. The Alliance has made timely filings of the Quarterly Financial Information for the quarters September 30, 2008, through June 30, 2011. The Alliance believes it has now made all filings required under all of its continuing disclosure undertakings.

RELATIONSHIPS OF PARTIES

As noted above, the Alliance or its affiliates have entered into interest rate swaps and other financial transactions with affiliates of the Underwriters.

From time to time, Bond Counsel and Hunton & Williams LLP (1) have represented the Alliance in other matters, and may do so in the future and (2) have represented and continue to represent certain of the Banks in unrelated matters. Bond Counsel also has represented one or more of the Underwriters in unrelated transactions. Anderson, Fugate & Givens, counsel to the Alliance, receives a substantial portion of its annual legal fee income from the Alliance. The Alliance typically engages in bidding to select the contractors for its capital projects. Whether or not such projects are bid, from time to time the contractor selected may be one in which members of the board of directors of either of the Issuers or the Alliance have an interest.

MISCELLANEOUS

This Official Statement and its distribution and use by the Underwriter have been duly authorized and approved by the Issuers and by the Alliance. This Official Statement has been executed and delivered by the Chairman of each Issuer on behalf of each Issuer and by the Senior Vice President and Chief Financial Officer of the Alliance on behalf of the Alliance.

So far as any statements made in this Official Statement involve matters of opinion, forecasts or estimates, whether or not expressly stated, they are set forth as such and not as representations of fact.

The Appendices are an integral part of this Official Statement and must be read together with all other parts of this Official Statement.

THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF THE CITY OF JOHNSON CITY, TENNESSEE

By: /s/ *W. Hanes Lancaster*
Chairman

INDUSTRIAL DEVELOPMENT AUTHORITY OF SMYTH COUNTY

By: */s/ Clarence F. Smith*
Chairman

MOUNTAIN STATES HEALTH ALLIANCE

By: */s/ Marvin H. Eichorn*
Senior Vice President and Chief Financial Officer

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APPENDIX A

MOUNTAIN STATES HEALTH ALLIANCE

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HISTORY AND OVERVIEW

Background

Mountain States Health Alliance (the "Alliance"), a Tennessee not-for-profit corporation headquartered in Johnson City, Tennessee, was originally incorporated as Memorial Hospital on April 12, 1945. In January 1951, the corporation acquired Appalachian Hospital and Training School, an 82-bed acute care facility in Johnson City, and simultaneously opened a 120-bed acute care facility in Johnson City. By 1977 its facilities had expanded to include 369 acute care beds and a 52-bed nursing home. In September 1980, the facilities were relocated and began operating as the Johnson City Medical Center ("JCMC"). In 1983 the corporation changed its name to the Johnson City Medical Center Hospital, Inc. The corporation has been determined to be an organization described in Section 501(c) (3) of the Internal Revenue Code of 1986, as amended.

In 1998, the Alliance purchased the assets and assumed certain liabilities of five hospitals and related assets from Columbia/HCA (the "1998 Acquisition") located in Johnson City, Kingsport and Elizabethton, Tennessee. In 1999, the corporation changed its name to Mountain States Health Alliance. On May 1, 2005, the Alliance purchased the assets of Woodridge Hospital, a 75-bed, acute inpatient psychiatric facility. On November 1, 2006, the Alliance purchased an 80% membership interest in Smyth County Community Hospital, which owns a 279-bed general acute care and long-term care facility in southwest Virginia. On October 31, 2007, the Alliance purchased a 50.1% membership interest in Norton Community Hospital, which owns and operates both Norton Community Hospital and Dickenson County Community Hospital in Southwest Virginia. On January 31, 2008, the Alliance acquired the assets and liabilities of Russell County Medical Center in Lebanon, Virginia. On April 1, 2009, the Alliance acquired a 50.1% interest in Johnston Memorial Hospital, which owns a 116-bed facility in Abingdon, Virginia. Listed below are facilities currently owned or controlled by the Alliance:

Facility	Location	Licensed Beds
Johnson City Medical Center ("JCMC")*	Johnson City, TN	514
James H. & Cecile Quillen Rehabilitation Hospital ("Quillen") *	Johnson City, TN	60
Woodridge Hospital ("Woodridge")*	Johnson City, TN	84
Franklin Woods Community Hospital ("Franklin Woods")	Johnson City, TN	80
Indian Path Medical Center ("Indian Path")	Kingsport, TN	261
Sycamore Shoals Hospital ("Sycamore Shoals")	Elizabethton, TN	121
Johnson County Community Hospital ("Johnson County Community ")	Mountain City, TN	2
Smyth County Community Hospital ("Smyth County Community") (1)	Marion, VA	279
Norton Community Hospital ("Norton Community") (2)	Norton, VA	129
Dickenson Community Hospital ("Dickenson Community") (2)	Clintwood, VA	25
Russell County Medical Center ("Russell")	Lebanon, VA	78
Johnston Memorial Hospital ("Johnston Memorial") (2)	Abingdon, VA	116
		1,749

*JCMC, Quillen and Woodridge are operated under a single 658-bed hospital license.
(1) 80% membership interest held by the Alliance.
(2) 50.1% membership interest held by the Alliance.

In addition to the above-described hospital facilities, the Alliance owns directly or through wholly-owned subsidiaries, medical office buildings, physician practices, undeveloped land and outpatient surgery centers.

Operations of the Alliance

The facilities of the Alliance are naturally divided geographically into two groupings: (i) the "Tennessee Facilities," which include JCMC, Quillen, Woodridge, and Franklin Woods Community Hospital, all in Washington County; Indian Path, in Sullivan County; Sycamore Shoals, in Carter County; and Johnson County Community, in Johnson County; and (ii) the "Virginia Facilities," which include Smyth County Community, in Smyth County; Norton Community, in the City of Norton; Dickenson Community, in Dickenson County; Russell, in Russell County; and Johnston Memorial, in Washington County. All of the Tennessee hospital facilities and Russell County Medical Center are owned by the Alliance, which is an Obligated Issuer under the Master Indenture. Smyth County Community is owned by Smyth County Community Hospital, and Norton Community is owned by Norton Community Hospital, both of which corporations will become Obligated Issuers upon the issuance of the Series

2011 Bonds. The remaining Virginia hospital facilities are all owned by entities that are not Obligated Issuers. The only other Obligated Issuer is Blue Ridge Medical Management Corporation, which is described further below.

Johnson City Medical Center is a 514 licensed bed, general acute care facility located on a 75-acre site on State of Franklin Road, a major regional thoroughfare in Johnson City. JCMC provides a wide array of acute care services on an inpatient and outpatient basis, including a complete range of cardiovascular, neurology, oncology, skilled nursing, and rehabilitation services. JCMC also operates a 69 licensed bed children's hospital with the region's only pediatric-specific emergency department. JCMC is designated as a Level III Perinatal Center and a Level I trauma center. JCMC earned international recognition as a Magnet Hospital by the American Nurses Credentialing Center. On or adjacent to JCMC's main campus are seven physician office buildings providing office space for approximately 75 physicians.

The James H. & Cecile C. Quillen Rehabilitation Hospital (formerly Northeast Tennessee Rehabilitation Hospital) is a 60 licensed bed rehabilitation and skilled nursing hospital in Johnson City, operated under the JCMC license. This facility provides a complete array of skilled nursing services as well as rehabilitative services for individuals with brain injury, stroke, or spinal cord injury. These rehabilitative services include respiratory, occupational and physical therapy, as well as outpatient services. The facility was constructed in 1991.

Woodridge Hospital is an 84 licensed bed, acute-care facility located in Johnson City, offering psychiatric and substance abuse services. This facility was purchased in May, 2005 and is operated under the JCMC license.

Franklin Woods Community Hospital is an 80 licensed bed facility offering a full array of primary care and some specialty services. Franklin Woods opened in July 2010 (replacing Johnson City Specialty and North Side) and was the first "green" hospital in the state.

Indian Path Medical Center is a 261 licensed bed facility in Kingsport. This facility provides a complete range of medical/surgical, acute care, psychiatric and skilled nursing services on an inpatient basis and a full complement of outpatient services. The facility is located on an 80 acre campus that also includes nine medical office buildings. Indian Path Medical Center was constructed in 1974.

Sycamore Shoals Hospital is a 121 licensed bed general acute care hospital in Elizabethton, Tennessee (Carter County). The facility provides inpatient, geropsychiatric, and outpatient services for acute care and medical/surgical patients. Sycamore Shoals was founded in 1955 as Carter County Memorial Hospital. It was moved to a newly constructed facility in 1986. A medical office building constructed in 2010 is also located on the main campus.

Johnson County Community Hospital is a facility located in Mountain City with two licensed beds and critical access designation. Johnson County offers inpatient care, emergency care and outpatient services.

Smyth County Community Hospital is a 279 licensed bed, general acute, skilled and long term care hospital in Marion, Virginia, owned by Smyth County Community Hospital (the "Smyth County Corporation"), a Virginia non-stock corporation in which the Alliance owns an 80% interest. The current facility was built in 1945, and provides a full range of acute inpatient and outpatient care, including OB/GYN, general surgery, urology, ENT, orthopedics, cardiology, oncology, and skilled nursing services. Nursing home services provided by Francis Marion Manor, a 109 licensed bed long term care facility, are included as part of Smyth County Community's bed complement. Smyth County Corporation will be joining the Obligated Group upon the issuance of the Series 2011 Bonds.

A new Smyth County Community Hospital facility is under construction off U.S. Interstate 81 at Exit 47 along Highway 11. The new facility will have 44 private rooms (30 acute care beds and 14 rehabilitation beds). The new facility will offer all of the services offered at the current facility with some improvements, including three modern surgery rooms. The new facility is expected to open in the spring of 2012 and meet U.S. Green Building Council's LEED standards to create a "green" facility.

Norton Community Hospital, located in the City of Norton, Virginia, is a 129 licensed bed, acute-care facility, serving Southwest Virginia and Southeastern Kentucky since 1949. Norton Community is owned and operated by Norton Community Hospital (the "Norton Corporation"), a Virginia non-stock corporation in which the Alliance owns a 50.1% interest. The largest healthcare facility in the coalfield region, Norton Community provides

a wide array of services through highly trained physicians and support staff. Norton Community is a member of the Virginia Hospital and Healthcare Association and is accredited by the American Osteopathic Association. Norton Community was the first AOA accredited teaching facility in the state of Virginia. The Norton Corporation will be joining the Obligated Group upon the issuance of the Series 2011 Bonds.

Dickenson Community Hospital, located in Clintwood, Virginia, opened in November 2003. It is a 25 licensed bed critical access hospital owned and operated by the Norton Corporation. A recent expansion included a 5,700 square foot physician office building on the hospital campus. Dickenson Community offers laboratory, imaging, inpatient acute care and a wide array of therapy services. Dickenson Community is not an Obligated Issuer.

Russell County Medical Center is a 78-bed acute care hospital located in Lebanon, Virginia, which includes a 20-bed inpatient psychiatric unit. Russell offers cardiac, home health, hospice, surgical and behavioral healthcare services. Russell is wholly owned by the Alliance, which is an Obligated Issuer.

Johnston Memorial Hospital is a 116 licensed bed, general acute care hospital in Abingdon, Virginia, which can trace its history back to a 12 bed facility started in 1905. Johnston Memorial provides a wide array of healthcare services in a newly constructed facility that opened in 2011. Johnston Memorial is owned and operated by Johnston Memorial Hospital, Inc. (the "Johnston Corporation"), in which the Alliance owns a 50.1% interest. Simultaneously with the issuance of the Series 2011 Bonds, the Industrial Development Authority of Smyth County will issue its Hospital Facility Revenue Refunding and Improvement Bonds (Johnston Memorial Hospital Project), Series 2011 (the "JMH Bonds"), for the benefit of Johnston Memorial. The Johnston Corporation is not a member of the Obligated Group and the Obligated Issuers are not required to pay debt service on the JMH Bonds.

Operations of Subsidiary and Other Affiliates

The Alliance directly owns and operates the hospital facilities listed above that are located in Tennessee, and directly owns and operates Russell in Lebanon, Virginia. It has controlling membership interests in the corporations that own Smyth County Community, Norton Community, Dickinson Community and Johnston Memorial. Additionally, the Alliance owns or otherwise controls a number of for-profit and not-for-profit affiliates that provide complementary health care services and help support the health care needs of the region. The principal affiliates are Mountain States Foundation, Inc., Mountain States Health Alliance Auxiliary and Blue Ridge Medical Management Corporation ("Blue Ridge").

Blue Ridge is a Tennessee for profit stock corporation, and the Alliance owns 100% of its stock. Blue Ridge in turn owns all of the stock or other ownership interest in the following entities (collectively, the "Blue Ridge Affiliates"): Mountain States Physician Group, Inc., Mountain States Properties, Inc., Mediserve Medical Equipment of Kingsport, Inc., Wilson Pharmacy, Inc., and Synergy Health Group LLC. While Blue Ridge is an Obligated Issuer under the Master Indenture along with the Alliance, none of the Blue Ridge Affiliates are an Obligated Issuer. Blue Ridge provides, directly or through Blue Ridge Affiliates, management services for 36 primary care facilities, 40 specialty care facilities, five urgent care and occupational management services facilities in 81 separate locations in ten counties. Through the 81 sites, Blue Ridge provides management services to a total of 181 practicing physicians, 50 nurse practitioners, nine physician assistants and five nurse anesthetists. Blue Ridge has various levels of ownership in five surgery centers and owns and/or manages a total of 26 medical office buildings, six of which are held in condominium-ownership form.

Inpatient Bed Complement

The following table shows the Alliance's licensed bed capacity by service line as of September 1, 2011:

Service	Licensed Beds	Distribution
Medical/Surgical	1,110	63%
OB/GYN	85	5
Critical Care	133	8
Neonatal	51	3
Psychiatry	136	8
Rehabilitation	55	3
Skilled Nursing / Nursing Home	179	10
Total	1,749	100%

Source: The Alliance.

Educational Programs

Pursuant to an agreement with the Division of Health Sciences at East Tennessee State University ("ETSU"), the Alliance provides JCMC as a site for clinical and other training of medical students and residents from ETSU's James H. Quillen College of Medicine ("QCM"), nursing students at the associate, baccalaureate and master's level from the School of Nursing and students from the School of Public and Allied Health. Woodridge provides sites for clinical training for QCM psychiatric residents. Approved medical residencies are offered by ETSU in Family Medicine, Internal Medicine/Psychiatry, OB/GYN, Pathology, Pediatrics, Cardiology, Infectious Disease, Pulmonary/Critical Care, Sleep and General Surgery. Approved fellowships are offered by ETSU in Gastroenterology and Medical Oncology. JCMC is also a clinical site for various health professional and allied health programs located in Tennessee, Kentucky, Virginia and North Carolina.

QCM, which is located adjacent to JCMC, has made a commitment to promote medical educational programs in Johnson City, Tennessee. With QCM's location adjacent to JCMC and the Veteran Affairs Medical Center at Mountain Home, a large portion of QCM's clinical training occurs at JCMC. An ETSU facility housing clinical training programs is located across the street from JCMC. QCM's presence promotes the presence of substantial numbers of physicians in private practice. Additionally, the concentration of medical specialists, researchers and medical educators in Johnson City make the Alliance competitively stronger in patient care opportunities in the region and also provides a good source of nurses for Alliance facilities.

Licenses and Accreditation

The Tennessee Facilities are licensed by the State of Tennessee Department of Health and Environment; the Virginia Facilities are licensed by the Virginia Department of Health; Norton Community Hospital and Dickenson Community Hospital are accredited through the Healthcare Facilities Accreditation Program ("HFAP") and all other facilities are accredited by The Joint Commission ("TJC"). Norton and Quillen are accredited by the Commission of Accreditation of Rehabilitation Facilities. The Alliance facilities are accredited by the College of American Pathologists. JCMC is also accredited by the American College of Surgeons Commission on Cancer and is designated as a Regional Perinatal Center by the Tennessee Department of Health and Environment.

Employees

As of August 31, 2011, the Alliance employs a staff of 9,146 persons (equal to approximately 7,758 full-time equivalent employees), including 2,275 registered/licensed practical nurses. The Alliance's employees are covered for a variety of employee benefits, including a qualified defined contribution pension plan, health and dental insurance, life insurance and vacation, holiday and sick time benefits. Certain employees at Norton Community and Dickenson Community are represented by a union. The Alliance has never experienced a strike or other work stoppage by its employees. The Alliance considers its employee relations to be excellent.

Pension Plan

The Alliance has a qualified defined contribution pension plan covering substantially all of its employees. Benefits payable to an employee under the terms of the pension plan are determined at the time of employee retirement. Contributions to the pension plan are current.

Insurance; Litigation

The Alliance is self-insured and has established self-insurance reserves to provide for professional and general liability claims and related expenses in amounts based upon an annual actuarial valuation. The self-insurance program currently has the following limits: $10,000,000 per claim; with an annual aggregate of $15,000,000. The Alliance has never had a claim to exceed the self-insurance limits. The Alliance maintains a $25,000,000 excess/umbrella policy, which attaches over the self-insurance fund's $10,000,000 per claim, $15,000,000 annual aggregate retention.

Additionally, the Alliance is self-insured for employee health and worker's compensation claims for the Tennessee Facilities. For the Virginia Facilities, the Alliance is self-insured for employee health and maintains a large deductible policy for worker's compensation claims with limits of $750,000 per employee per accident, $2,500,000 aggregate, $5,000,000 all covered bodily injury aggregate maximum for the policy period. The Alliance recognizes expense each year based upon actual claims paid and an estimate of claims incurred, but not yet paid. The Alliance has established a reserve for reported and unreported worker's compensation claims based upon an annual actuarial valuation.

The Alliance and related entities are defendants in litigation relating to medical malpractice, worker's compensation and other claims arising in the ordinary course of business. Based on an evaluation of pending and threatened actions, management of the Alliance does not believe that any existing litigation, individually or collectively, would materially and adversely affect the financial resources of the Alliance or the business or continuous operation of the Alliance. Furthermore, the Alliance has accrued amounts in its self-insurance reserves at levels that it believes are sufficient to provide for payments reasonably projected to be due in connection with pending and potential claims and liabilities of the Alliance.

MEDICAL SERVICES

The Alliance provides a wide range of general and specialty medical services for the residents of Northeast Tennessee and Southwest Virginia and the surrounding states of Kentucky and North Carolina. The majority of tertiary care provided by the Alliance is concentrated at Johnson City Medical Center. Some highlights of the medical services and programs offered by the Alliance are described below.

Surgical Services. The Alliance has approximately 60 operating rooms located in eight facilities. The Alliance's surgical facilities are equipped with state-of-the-art technologies to meet the health care needs of the region. The Alliance provides services in all major surgical specialties including orthopedics, vascular, cardiothoracic, neurological, general, gynecological, laparoscopic, laser, urological, oncological, pediatric, plastic, ear, nose and throat, dental and transplant services.

Cardiovascular Services. The Alliance offers comprehensive regional cardiac services and highly advanced equipment for the detection, treatment, care and rehabilitation of those with heart problems. Advanced services include a wide range of non-invasive tests, cardiac catheterization, angioplasty and open-heart surgery. The Center for Cardiovascular Health at JCMC is known throughout the region for its medical expertise in cardiac care and has been recognized as the region's top hospital for cardiovascular services by US News and World Report in 2010 and 2011. Indian Path provides cardiovascular services including interventional cardiology and Johnston Memorial has recently expanded services to include cardiac catherization.

Pulmonary Medicine. Respiratory therapy services are provided at each of the Alliance's facilities. The Center for Pulmonary Medicine at JCMC diagnoses and manages disorders of the respiratory and the pulmonary vascular systems, including emphysema and black-lung disease. A state-of-the-art metabolic laboratory assesses heart and respiratory problems. Pulmonary outreach services are provided at JCMC.

Comprehensive Wound Care is provided at JCMC, Norton Community, and Johnston Memorial. JCMC is the home to three hyperbaric oxygen chambers and Norton Community and Johnston Memorial each have one chamber

Women's Services. The Alliance provides specially designed women's services equipped to meet the unique health needs of women. Locations for obstetric and newborn care include The Family Birth Centers at JCMC, Franklin Woods, Indian Path, Sycamore Shoals, Norton Community, and Johnston Memorial. Gynecologic care is provided at each of the preceding facilities as well as Smyth County Community. The complement of women's services includes: routine and high-risk obstetrical care, gynecological surgery, breast disease diagnosis and treatment, fertility services, laser and microscopic surgery, plastic surgery, wellness/fitness programs, and educational sessions covering a wide spectrum of women's concerns. The Family Birth Center at JCMC includes the region's only State-designated Perinatal Center for pregnancy and newborn medical complications and a transport team to bring critically ill infants to JCMC.

Children's Services. The Niswonger Children's Hospital at JCMC is the only children's hospital in northeast Tennessee. More than 20 pediatric subspecialties provide specialty care through this 69 licensed bed "hospital within a hospital" and pediatric emergency department. The Children's Hospital has met stringent criteria to become a member of the National Association of Children's Hospitals and Related Institutions (NACHRI), linking providers and staff with more than 130 of the nation's leading pediatric facilities. Also located on the campus of JCMC is the region's only *Ronald McDonald House*, with the mission of meeting the support needs of pediatric patients and family members. In addition, in October 1999, the Alliance entered into a clinical affiliation with St. Jude's Children's Research Hospital to provide pediatric cancer and other catastrophic disease treatment services.

Diabetes Services. The Alliance provides diabetes management programs with specialized healthcare providers able to address the needs of the diabetic patient. The diabetes services emphasizes the importance of patient education and support with both patient and family involvement in the treatment process and provides education in all aspects of diabetes management.

Rehabilitation Services. The James H. and Cecile C. Quillen Rehabilitation Hospital provides a complete range of physical rehabilitative services for the region, including specialized rehabilitative services for individuals with brain injuries, strokes and spinal cord injuries. The Alliance also provides outpatient physical, occupational, and speech therapies at eight locations for individuals with physical disabilities.

Cancer Services. The Alliance provides comprehensive cancer treatment services throughout the system with four tertiary care facilities in Johnson City, Kingsport, Abingdon, and Marion. The Regional Cancer Center at JCMC serves as a referral center and education host for students, and is the only facility within several hours travel time with specialized infrastructure capable of supporting the treatment of complex cases such as pediatric cancers and acute leukemia. The St. Jude's Children's Research Hospital, Tri-Cities Affiliate, is located on JCMC's campus. It is a collaborative effort between the Alliance, East Tennessee State University, and St. Jude's Children's Research Hospital in Memphis to provide pediatric oncology services in the region. Regional Cancer Centers at Indian Path, Johnston Memorial, and Smyth County Community provide surgical and chemotherapy treatments to patients from northeast Tennessee and southwest Virginia. Outpatient radiation services are provided at Regional Cancer Centers at Indian Path and Johnston Memorial. The program emphasizes the use of market-leading facility design, multi-specialty team-based care, highly trained and certified sub-specialty staff and an emphasis on patient-centered care.

Behavioral Health Services. Respond/Crisis Line provides information, assessment, and referral assistance to patients in need of psychiatric services. Services are provided at three locations. Woodridge provides inpatient care for children, adolescents, adults, and geriatric populations and outpatient services, including Intensive Outpatient Program for adults. Sycamore Shoals provides inpatient Geropsych services. Russell provides inpatient acute psychiatry and outpatient services for adults.

In addition to the services described above, the Alliance offers many other services throughout the region including emergency departments and urgent care centers, skilled nursing facilities, and the medical air transport service called *WINGs Air Rescue*.

Medical Staff

As of June 30, 2011, there were 1,027 physicians and dentists on the Alliance's active, courtesy and consulting medical staffs. Of the 1,027 physicians on staff, 880 are board certified in their specialty. The average age of the medical staff is 49 years.

Medical staff appointment is available to licensed physicians, dentists, podiatrists and certain other professionals who are licensed to practice in the State of Tennessee or Virginia, as applicable, and who meet other specific requirements of the medical staff by-laws. Appointments and re-appointments are made by the Alliance Board of Directors upon the recommendations of the various medical staffs and the Alliance's administrative staff. Associate staff members are persons who have applied for active staff membership, but have been on the staff for less than two years.

The Alliance conducts a recruitment program to support the recruiting efforts of the affiliated medical staff. Recruiting assistance is provided to both private and university affiliated physicians as requested, and includes contracting and interaction with recruiting firms, receipt and screening of candidates' curriculum vitae, candidate site visit, and relocation and initial practice management assistance to the new physicians.

GOVERNANCE AND MANAGEMENT

Board of Directors

The management of the Alliance's affairs is vested in a Board of Directors consisting of not less than 9 and not more than 14 members, including the President/CEO, who serves as an ex-officio member. Except for the ex-officio member, directors serve for staggered three-year terms. Standing committees of the Board of Directors include Executive, Governance/Nominating, Corporate Audit and Compliance, and Quality. Special committees may be appointed by the Chairman of the Board for specific assignments. Current officers and members of the Board of Directors and their occupations and dates of expiration of their terms are set forth below:

Name and Office Held	Business Affiliation	Term Expiration
Robert Feathers Chairperson	President Workspace Interiors, Inc	2012
Barbara Allen Vice Chairperson	Owner, Manager Stowaway Storage	2013
Clem Wilkes, Jr. Treasurer	Financial Advisor Raymond James Financial Services	2014
Joanne Gilmer Secretary	Retired General Shale	2014
Don Jeanes Past-Chair	Retired Milligan College	2015
Sandra Brooks, M.D.	Pathologist Watauga Pathology Associates	2012
Mike Christian	Retired Banker	2012
Jeff Farrow, M.D.	Pulmonologist Johnson City Medical Center	2015
Tom Fowlkes	General Counsel The United Company	2015
Linda Garceau	Dean, College of Business & Technology East Tennessee State University	2015
David May, M.D.	Anesthesiologist Sycamore Shoals Anesthesia Assoc.	2014
Gary Peacock	Retired Royal Mouldings Ltd.	2014
Dennis Vonderfecht *Ex-Officio*	President and CEO Mountain States Health Alliance	n/a

Further, five community-based boards serve as advisory boards for the Alliance's Board of Directors. The community-based boards represent the communities serviced by the following facilities: (1) Sycamore Shoals), (2) Johnson County Community, (3) Russell, (4) Indian Path and (5) Franklin Woods and JCMC. Four governing boards serve the Alliance's joint-ventured facilities and include: (1) Dickenson Community, (2) Johnston Memorial, (3) Norton Community, and (4) Smyth County Community. One other governing board oversees the operations of Blue Ridge Medical Management Corporation. The bylaws of the community boards are rooted in the Alliance's bylaws and the remaining boards are distinguished through separate bylaws. The bylaws of each of the community boards provide that their boards consist of no fewer than nine and no more than 18 persons. No more than thirty-three percent of the directors of each Community Board may consist of physicians. Terms vary for the remaining boards, but are predominately staggered for three-year terms.

Management of the Corporation

The President and Chief Executive Officer, selected by the Board of Directors, manages the Alliance's administrative staff and has the authority and responsibility of system-wide direction of the Alliance's facilities, subject to policies adopted by the Board of Directors or any of its committees to which it has delegated power for such action. The principal members of the administrative staff of the Alliance are described below.

Dennis Vonderfecht (60) – President and Chief Executive Officer. Mr. Vonderfecht has served as President and CEO since January 1990. Prior to joining the Alliance, he was employed by Research Health Services System in Kansas City, Missouri, where he held the position of Regional Vice President. Mr. Vonderfecht worked for Humana, Inc. for approximately eight years in capacities such as: Administrative Specialist at Humana Hospital, Greensboro, North Carolina; Associate Administrator at Gibson General Hospital, Trenton, Tennessee; Associate Executive Director for Humana Hospital, Brandon, Florida; Associate Executive Director, Humana Hospital, Greensboro, North Carolina; Project Manager for Parkway Medical Center, Cary, North Carolina; and as Executive Director, Humana Hospital, Newnan, Georgia. Mr. Vonderfecht's undergraduate study was at Colorado State University, and the University of Nebraska, where he was awarded a B.S. degree in Business Administration. He obtained two master's degrees from the University of Missouri, one in Business Administration and the other in Hospital Administration. He also holds an honorary doctorate from Milligan College. He presently serves on the Boards of Directors of Premier, Inc., ETSU Foundation, Tennessee Hospital Association, Tennessee Business Roundtable, Tennessee Valley Corridor Inc., and the Tennessee Center for Performance Excellence. Mr. Vonderfecht currently serves as Chairman of the Board for the Tennessee Center for Performance Excellence and has previously served as Chairman of the Tennessee Hospital Association Board of Directors and Chairman of the Board of Hospital Alliance of Tennessee. Mr. Vonderfecht is a Fellow in the American College of Healthcare Executives. He has been the recipient of the Distinguished Service Award and the Meritorious Service Award from the Tennessee Hospital Association and was awarded the American College of Healthcare Executives Regent's Award. He has also been recognized with the Health Care Heroes Award, as well as the Cup of Kindness Award through the Tri-Cities Business Journal. In addition, Mr. Vonderfecht was presented with a "Leaders in Christian Service" award by Milligan College and has received recognition as an "Honorary Alumni" by East Tennessee State University.

Marvin Eichorn (55) - Senior Vice President and Chief Financial Officer. Mr. Eichorn has served the Alliance since August 1998, when he joined as Senior Vice President/Regional Operations. He was named Chief Financial Officer in January 1999. As Senior Vice President/Chief Financial Officer, he is responsible for all of the financial operations and services of the Alliance as well as managed care and physician operation activities for the Alliance. Prior to joining the Alliance, he was employed by Covenant Health/Fort Sanders Health System in Knoxville, Tennessee in various positions over a 14 year period including Executive Vice President/Non-Hospital Operations and Executive Vice President/Chief Financial Officer. Mr. Eichorn is a Certified Public Accountant and is a member of various health care and finance organizations. His educational background includes a bachelor's degree in finance from the University of West Florida and a master's degree in business administration from Milligan College. In 2000, Mr. Eichorn received the Meritorious Service Award for an Executive Staff member from the Tennessee Hospital Association. He also serves on the board or key committees of various national and regional healthcare related organizations.

Candace Jennings (57) **-** Senior Vice President for Tennessee Operations. Ms. Jennings joined the Alliance in 2007 as Vice President and Chief Operating Officer for Washington County, Tennessee operations. Her current responsibilities include the strategy development and operation of the Alliance's eight Tennessee hospitals, including a critical access hospital (Johnson County Community Hospital), a children's hospital (Niswonger

Children's Hospital) and a new, LEED certified hospital, Franklin Woods Community Hospital which opened in July 2010. Prior to joining Mountain States Health Alliance, she was Chief Nursing Officer for St. John's Hospital in Springfield, Illinois. As a consultant with Ernst and Young, she led organizations through transformational change specializing in organizational resizing and patient focused care. She has served as a health care leader for over 20 years in tertiary teaching hospitals in Alabama, Texas, Illinois and Tennessee. Her educational background includes bachelors and master's degrees in Nursing and a master's in Health Services Administration from the University of Alabama at Birmingham (UAB). Ms. Jennings has been a Fellow in ACHE since 2001.

Ann Fleming (63) – Senior Vice President of Virginia Operations and System Cardiovascular and Oncology Strategic Service Units. Since joining the Alliance in March 2007, Ms. Fleming has served as an examiner for the Tennessee Center for Performance Excellence and a board member for the Senate Productivity and Quality Award. Prior to joining the Alliance, Ms. Fleming most recently served as VP Clinical Service Lines, Merrillville Hospital Administrator and Chief Nursing Officer at The Methodist Hospitals Inc., Gary and Merrillville, Indiana. As part of her work there, she launched the Cardiovascular, Oncology, Rehabilitation/Ortho/Neuro, Women's and Children Service Lines. Ms. Fleming also served as Rehabilitation Consultant at Porter Memorial Hospital, Valparaiso, Indiana, and served as an operating room nurse with the 475th MASH during Operation Desert Storm in Saudi Arabia and Iraq. She received a bachelor's degree in nursing from the University of Kentucky, and a master's degree in Public Administration from Kentucky State University. Ms. Fleming is a member of the American College of Health Care Executives, the Association of Nursing Executives and the Medical Group Management Association. She received the Army Commendation Medal in 1991. Ms. Fleming is a Registered Nurse, currently licensed in Tennessee, Kentucky, Virginia and Indiana.

Morris Seligman (55) – Senior Vice President and Chief Medical Officer. Dr. Seligman joined the Alliance in January 2010, and has responsibility on a system-wide basis for Medical Staff Services, Graduate Medical Education, Continuing Medical Education, Patient Resource Management (case management), Clinical Research, Accreditation, Infection Prevention, Patient Safety, Quality, Information Systems, Telecommunications, and Clinical Informatics. Prior to joining the Alliance, Dr. Seligman was employed by Trinity Regional Health System Quad Cities-Senior Affiliate of Iowa Health System, Illinois and Iowa, where he served as the Chief Medical Officer and Vice President for Physician Services. Dr. Seligman is a diplomat of the American Board of Quality Assurance Utilization Review Physicians, a Fellow of the American Institute of Healthcare Quality certified in Healthcare Quality Management (CHCQM), a Fellow of the American College of Physicians (FACP), a Fellow of the American College of Healthcare Executives (FACHE), and a Certified Physician Executive (CPE). Dr. Seligman also has a two year degree in Engineering Sciences. Dr. Seligman is a board certified internist by training and has practiced Internal Medicine, Emergency Medicine and Occupational Medicine. Dr. Seligman received his MD from the University of Missouri-Columbia and his BSBA/MBA from Washington University. Dr. Seligman also earned his CPA Certificate and previously worked at Arthur Andersen & Co.

John Schario (53), Senior Vice President, Consumer Health Services/Innovation. Prior to joining the Alliance in July 2011, Mr. Schario most recently served as Chief Executive Officer of Nueterra Holdings LLC, a privately held health care equity and management company that specializes in acquiring and developing ambulatory surgery centers, surgical hospitals and physical therapy centers. Under Mr. Schario's leadership, the company grew from nine surgical facilities to 62 surgical facilities and 30 physical therapy clinics over a ten year period. Prior to Mr. Schario's involvement with Nueterra, he held various junior and senior level management positions over a twenty-one year period with Health Midwest, a large integrated health care system in Kansas City. These positions included leadership of various business development enterprises, including mobile services, clinical outreach services, diagnostic imaging services, and employer health services. During his tenure with Health Midwest, he also served as administrator of a small, rural hospital and Vice President of the large, flagship tertiary hospital with responsibilities for cardiology, neurology, radiology, laboratory, pharmacy, physical therapy, occupational therapy and respiratory therapy. Mr. Schario holds bachelors and master's degrees from Rockhurst University in Kansas City.

SERVICE AREA, MARKET SHARE AND COMPETITION

Patient Origin

The Alliance operates hospital facilities located in the Counties of Washington, Sullivan, Carter, and Johnson in the northeastern region of Tennessee. In the southwestern region of Virginia, the Alliance operates facilities in the Counties of Smyth, Wise, Dickenson, Russell and Washington, and in the City of Norton. The core service area for the Alliance (the "Core Service Area") consists of Washington, Sullivan, Carter, Johnson, Greene,

Hawkins, and Unicoi Counties in Tennessee and Smyth, Russell, Wise (including the City of Norton), Dickenson, Scott, and Washington Counties (including Bristol City) in Virginia. Approximately 93.3% of the Alliance's discharges originated from the Core Service Area for the fiscal year ended June 30, 2010. The patient origin analysis from all service areas (i.e., both the Core Service Area and the Non-Core Service Area, as defined below) as a percent of the Alliance's discharges for fiscal years 2007, 2008, 2009 and 2010 is presented in the following table:

Alliance Facilities Patient Origin
By Fiscal Year (June 30)

	2007		2008		2009		2010	
	Discharges	Percent	Discharges	Percent	Discharges	Percent	Discharges	Percent
Core Counties								
Washington, TN	16,435	34.2%	16,455	30.3%	15,196	26.6%	16,167	26.9%
Sullivan, TN	8,121	16.9	8,092	14.9	7,312	12.8	7,753	12.9
Carter, TN	6,728	14.0	6,625	12.2	5,884	10.3	6,371	10.6
Wise, VA [1]	865	1.8	4,453	8.2	4,170	7.3	4,327	7.2
Greene, TN	2,643	5.5	2,661	4.9	2,514	4.4	2,644	4.4
Smyth, VA	2,307	4.8	2,498	4.6	3,485	6.1	3,606	6.0
Unicoi, TN	2,259	4.7	2,172	4.0	1,942	3.4	1,863	3.1
Johnson, TN	2,018	4.2	2,009	3.7	1,771	3.1	1,923	3.2
Hawkins, TN	1,730	3.6	1,738	3.2	1,542	2.7	1,503	2.5
Russell, VA	192	0.4	1,303	2.4	3,142	5.5	3,306	5.5
Dickenson, VA	240	0.5	1,195	2.2	1,200	2.1	1,442	2.4
Scott, VA	865	1.8	923	1.7	914	1.6	902	1.5
Washington, VA [2]	673	1.4	760	1.4	4,170	7.3	4,207	7.0
Core Subtotal	45,076	93.8%	50,886	93.7%	53,242	93.2%	56,015	93.2%
Non-Core Subtotal	1,874	3.9%	2,444	4.5%	2,856	5.0%	3,005	5.0%
Other Areas Subtotal	1,105	2.3%	978	1.8%	1,028	1.8%	1,082	1.8%
Total	48,055	100.0%	54,307	100.0%	57,127	100.0%	60,102	100.0%

Source: The Alliance – Fiscal year data excludes normal newborns. Acquired facilities have been included from date of acquisition forward.
(1) Includes City of Norton, Virginia, data.
(2) Includes City of Bristol, Virginia, data.

The Alliance has a strong extended market encompassing numerous counties in northeastern Tennessee, western North Carolina, southwestern Virginia, and southeastern Kentucky (the "Non-Core Service Area" and, together with the Core Service Area, the "Service Area"), as shown in the map in "Service Areas and Facility Locations" herein. As the table above shows, approximately 5.0% of discharges for the fiscal year ended June 30, 2010, were from the Non-Core Service Area, and approximately 1.8% of discharges were from beyond the Service Area. With the addition of Smyth County Community, Norton Community, Dickenson Community, Russell, and Johnston Memorial, the percentage of discharges from Virginia has increased. The Alliance is also a referral center for numerous advanced services such as high-risk obstetrics, perinatology, neonatology, cardiology, oncology and medical surgeries (including transplants and laparoscopies), and therefore serves many patients from outside the Service Area and outside Tennessee.

Service Area Facilities

The principal competitor of the Alliance in the Core Service Area is Wellmont Health System ("Wellmont"), which operates six of its eight hospitals within the Alliance's Core Service Area: Holston Valley Medical Center, in Kingsport, Tennessee; Bristol Regional Medical Center, in Bristol, Tennessee; Hawkins County Memorial Hospital, in Rogersville, Tennessee; Lonesome Pine Hospital, in Big Stone Gap, Virginia; Mountainview Regional, in Norton, Virginia; Hancock County Hospital, in Sneedville, Tennessee; and Takoma Adventist Hospital, in Greeneville, Tennessee. Certain operating statistics for the facilities of the Alliance and Wellmont located within Tennessee are set forth below:

Tennessee Service Area Hospitals and Related Facilities – Fiscal 2010

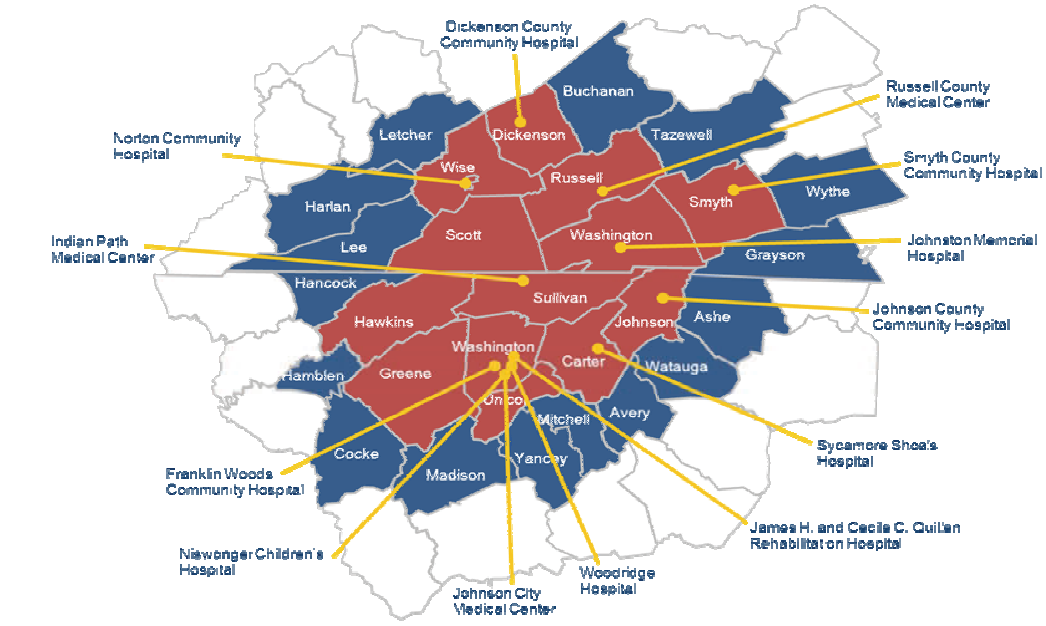
	County in Tennessee	Licensed Beds	Staffed Beds	Total Discharges	Total Patient Days	Average Daily Census
Mountain States Health Alliance						
Johnson City Medical Center	Washington	514	514	27,129	138,664	380
Quillen Rehabilitation Hospital	Washington	60	60	691	9,923	27
Woodridge Hospital	Washington	84	84	3,310	19,572	54
North Side Hospital	Washington	91	72	1,885	15,980	44
Johnson City Specialty Hospital	Washington	23	23	1,077	2,346	6
Indian Path Medical Center	Sullivan	261	191	6,549	28,532	78
Indian Path Pavilion	Sullivan	61	48	17	59	0
Sycamore Shoals Hospital	Carter	121	79	3,448	15,334	42
Johnson County Community Hospital	Johnson	2	2	29	69	0
MSHA Subtotal		**1,217**	**1,073**	**44,135**	**230,479**	**631**
Wellmont Health System						
Holston Valley Medical Center	Sullivan	455	339	19,531	87,488	240
Bristol Regional Medical Center	Sullivan	312	261	14,827	62,531	171
Hawkins County Memorial Hospital	Hawkins	50	46	1,710	5,165	14
Hancock County Hospital	Hancock	10	10	327	1,003	3
Takoma Regional Hospital	Greene	121	100	2,606	12,274	34
Wellmont Subtotal		**948**	**756**	**39,001**	**168,461**	**462**
Other Core Service Area Facilities						
Laughlin Memorial Hospital	Greene	140	140	4,531	18,302	50
Healthsouth Rehabilitation Hospital	Sullivan	50	50	947	14,500	40
Unicoi County Memorial Hospital	Unicoi	48	25	1,223	4,499	12
Other Core Service Area Facilities		**238**	**215**	**6,701**	**37,301**	**102**
Core Service Area Total		**2,403**	**2,044**	**89,837**	**436,241**	**1,195**

Source: 2010 Tennessee Joint Annual Reports.

Service Areas and Facility Locations

The Alliance's Core and Non-Core Service Areas are depicted in the map set forth below:

Mountain States Health Alliance
Service Area



Market Share

Market share represents the proportion of service area residents discharged from each of the service area hospitals. Market share by hospital for the defined service area was calculated using data published by the Tennessee Hospital Association, the Virginia Hospital and Healthcare Association and the North Carolina Hospital Association. Hospital specific discharges are divided by service area specific discharges to estimate market share for each of the service area hospitals.

The Alliance maintains the largest market share of its core service area, capturing over 51.8% of the market for the calendar year ended 2010. Wellmont's facilities had a market share for the same period of approximately 37.8%. The following tables present calendar years 2006, 2007, 2008, 2009, and 2010, Core Service Area and total Service Area market share information for facilities currently owned or controlled by the Alliance and Wellmont.

Core Service Area Market Share Summary

		Calendar 2006		Calendar 2007		Calendar 2008		Calendar 2009		Calendar 2010	
System	Hospital Name	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total
MSHA	Johnson City Medical Center	24,520	24.3%	24,427	24.3%	25,095	24.9%	25,168	25.9%	25,048	25.8%
	Indian Path Medical Center	5,495	5.4	5,340	5.3	5,867	5.8	5,526	5.7	6,035	6.2
	Sycamore Shoals Hospital	4,062	4.0	4,031	4.0	3,724	3.7	3,206	3.3	3,225	3.3
	Franklin Woods Community Hospital	3,515	3.5	3,106	3.1	2,655	2.6	2,384	2.5	2,683	2.8
	Johnson County Community Hospital	34	0.0	40	0.0	44	0.0	31	0.0	24	0.0
	Smyth County Community Hospital	2,115	2.1	2,139	2.1	2,113	2.1	2,164	2.2	1,958	2.0
	Norton Community Hospital	5,170	5.1	4,793	4.8	4,139	4.1	3,980	4.1	3,636	3.8
	Dickenson Community Hospital	805	0.8	757	0.8	366	0.4	7	0.0	2	0.0
	Russell County Medical Center	2,582	2.6	2,270	2.3	2,242	2.2	2,298	2.4	2,099	2.2
	Johnston Memorial Hospital	4,612	4.6	4,979	4.9	5,656	5.6	5,496	5.6	5,534	5.7
MSHA Total		52,910	52.4%	51,882	51.5%	51,901	51.4%	50,260	51.7%	50,244	51.8%
Wellmont	Wellmont Holston Valley Medical Center	15,693	15.5	16,556	16.4	16,057	15.9	16,260	16.7	16,724	17.3
	Wellmont Bristol Regional Medical Center	11,851	11.7	12,288	12.2	12,676	12.6	12,455	12.8	12,831	13.2
	Wellmont Lonesome Pine Hospital	2,630	2.6	2,745	2.7	2,656	2.6	2,181	2.2	2,005	2.1
	Wellmont Hawkins County Memorial Hospital	1,517	1.5	1,699	1.7	1,778	1.8	1,639	1.7	1,521	1.6
	Wellmont Hancock County Hospital	9	0.0	11	0.0	9	0.0	10	0.0	10	0.0
	Takoma Regional Hospital	2,103	2.1	2,227	2.2	2,320	2.3	2,093	2.2	1,827	1.9
	Lee Regional Medical Center	146	0.1	136	0.1	151	0.1	153	0.2	146	0.2
	Mountain View Regional Medical Center	1,915	1.9	1,880	1.9	2,058	2.0	1,597	1.6	1,601	1.7
Wellmont Total		35,864	35.5%	37,542	37.3%	37,705	37.4%	36,388	37.4%	36,665	37.8%
All Other		12,194	12.1%	11,271	11.2%	11,272	11.2%	10,628	10.9%	10,022	10.3%
Grand Total		100,968	100.0%	100,695	100.0%	100,878	100.0%	97,276	100.0%	96,931	100.0%

Source: Tennessee Hospital Association, the Virginia Hospital and Healthcare Association, and the North Carolina Hospital Association.
Notes:
Information based on calendar year and excludes normal newborns, psych, substance abuse, and rehab.
Acquired facilities are fully included retrospectively.
JCMC, Quillen, and Woodridge are reported together as "Johnson City Medical Center" because they operate under a single license.
Franklin Woods reflects historical values for North Side Hospital and Johnson City Specialty Hospital prior to June 2010.

Total Service Area Market Share Summary

		Calendar 2006		Calendar 2007		Calendar 2008		Calendar 2009		Calendar 2010	
System	Hospital Name	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total
MSHA	Johnson City Medical Center	25,755	17.1%	25,677	17.2%	26,404	17.6%	26,472	18.2%	26,259	18.3%
	Indian Path Medical Center	5,658	3.8	5,547	3.7	6,091	4.1	5,711	3.9	6,242	4.4
	Sycamore Shoals Hospital	4,078	2.7	4,048	2.7	3,736	2.5	3,214	2.2	3,239	2.3
	Franklin Woods Community Hospital	3,563	2.4	3,133	2.1	2,686	1.8	2,398	1.7	2,714	1.9
	Johnson County Community Hospital	35	0.0	40	0.0	46	0.0	31	0.0	24	0.0
	Smyth County Community Hospital	2,374	1.6	2,417	1.6	2,348	1.6	2,399	1.7	2,197	1.5
	Norton Community Hospital	5,531	3.7	5,085	3.4	4,337	2.9	4,174	2.9	3,807	2.7
	Dickenson Community Hospital	814	0.5	765	0.5	369	0.2	7	0.0	2	0.0
	Russell County Medical Center	2,870	1.9	2,563	1.7	2,478	1.7	2,587	1.8	2,368	1.7
	Johnston Memorial Hospital	4,960	3.3	5,342	3.6	6,094	4.1	5,978	4.1	5,928	4.1
MSHA Total		55,638	37.0	54,617	36.5	54,589	36.4	52,971	36.5	52,780	36.8
Wellmont	Wellmont Holston Valley Medical Center	17,333	11.5	18,504	12.4	17,984	12.0	18,155	12.5	18,723	13.1
	Wellmont Bristol Regional Medical Center	12,635	8.4	13,160	8.8	13,831	9.2	13,696	9.4	14,102	9.8
	Wellmont Lonesome Pine Hospital	3,183	2.1	3,377	2.3	3,266	2.2	2,681	1.8	2,421	1.7
	Wellmont Hawkins County Memorial Hospital	1,581	1.1	1,808	1.2	1,866	1.2	1,704	1.2	1,597	1.1
	Wellmont Hancock County Hospital	237	0.2	375	0.3	360	0.2	303	0.2	243	0.2
	Takoma Regional Hospital	2,274	1.5	2,358	1.6	2,441	1.6	2,219	1.5	1,935	1.3
	Lee Regional Medical Center	2,565	1.7	2,768	1.9	2,509	1.7	2,370	1.6	2,398	1.7
	Mountain View Regional Medical Center	1,996	1.3	1,977	1.3	2,132	1.4	1,652	1.1	1,661	1.2
Wellmont Total		41,804	27.8%	44,327	29.6%	44,389	29.6%	42,780	29.5%	43,080	30.0%
All Other		52,771	35.1%	50,651	33.9%	51,003	34.0%	49,314	34.0%	47,553	33.2%
Grand Total		150,213	100.0%	149,595	100.0%	149,981	100.0%	145,065	100.0%	143,413	100.0%

Source: Tennessee Hospital Association, the Virginia Hospital and Healthcare Association, and the North Carolina Hospital Association.
Notes:
JCMC, Quillen, and Woodridge are reported together as "Johnson City Medical Center" because they operate under a single license.
Franklin Woods reflects historical values for North Side Hospital and Johnson City Specialty Hospital prior to June 2010.

Demographic and Socio-Economic Characteristics of the Service Area

The following table provides information on major employers in the region:

Major Employers in the PSA/SSA

Rank	Employer	Headquarters	Estimated Employees	Industry
1	K-VA-T Food Stores	Abingdon, VA	12,600	Retail Supermarkets
2	Mountain States Health Alliance	Johnson City, TN	9,000	Health Care
3	Eastman Chemical Co.	Kingsport, TN	6,800	Manufacturer
4	Wellmont Health System	Kingsport, TN	6,500	Health Care
5	East Tennessee State University	Johnson City, TN	2,330	Higher Education
6	James H. Quillen VA Medical Center	Mountain Home, TN	2,000	Gov't Health Care Facility
7	Sullivan County Dept. of Ed	Blountville, TN	1,646	Public Education
8	Advanced Call Center Technologies	Berwyn, PA	1,500	Call Center
9	Washington County Dept. of Ed	Jonesborough, TN	1,300	Public Education
10	Hawkins County Board of Ed	Rogersville, TN	1,200	Public Education
11	DTR Tennessee, Inc.	Midway, TN	1,195	Manufacturer
12	A.O. Smith	Johnson City, TN	1,140	Manufacturer
13	Kingsport City Schools	Kingsport, TN	1,050	Public Education
14	Frontier Health	Johnson City, TN	996	Health Care
15	Bristol Compressors	Bristol, VA	950	Manufacturer

Source: 2010 Book of Lists (A supplement to The Business Journal).

SOURCES OF REVENUE

Patient service payments are made to the Alliance by commercial insurance carriers, the federal government under the Medicare program, the State of Tennessee under the TennCare program and surrounding states under their Medicaid programs. The table below shows the percentage of gross patient revenues received by the Alliance from each program and from private pay.

Gross Patient Revenues by Source of Payment (Payor Mix)

	Audited Fiscal Years Ended June 30				Unaudited June 30
	2007	2008	2009	2010	2011
Medicare	40.7%	41.3%	42.0%	43.4%	43.7%
TennCare/Medicaid	15.7	15.3	15.0	14.2	13.7
Managed Care/ Commercial and Other	36.6	36.4	35.7	34.2	34.2
Private Pay	7.0	7.0	7.3	8.2	8.4
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: The Alliance.

Medicaid and Medicare

Approximately 44% and 14% of the gross patient service charges of the Alliance for the fiscal year ended June 30, 2011, were derived from the Medicare and TennCare/Medicaid programs, respectively. Medicare provides certain health care benefits to beneficiaries who generally are 65 years of age and older, are long term disabled, or qualify for the end stage renal disease ("ESRD") program. Medicare Part A covers, among other things, inpatient hospital services, skilled nursing care, hospice and some home health care. Medicare Part B covers, among other things, physician services, outpatient hospital services and some supplies. TennCare/Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid.

TennCare/Medicaid

The State of Tennessee transferred a portion of its Medicaid program to a managed care program ("TennCare") under a Section 1115 Waiver effective January 1, 1994. The long term care and ESRD Medicaid programs were not transferred to TennCare. The TennCare program also covers a number of uninsured non-Medicaid beneficiaries.

Medicare

Medicare pays acute care hospitals for most services provided to inpatients under a payment system known as the Prospective Payment System ("PPS"). Separate PPS payments are made for inpatient operating costs and inpatient capital costs.

Inpatient Operating Costs. Under PPS, acute care hospitals are reimbursed for inpatient operating costs on a per-discharge basis at fixed rates established for identified Diagnosis Related Groups ("DRGs"). DRG classification is based on the diagnosis at discharge and major procedures and other factors for each particular Medicare patient. The amount to be paid for each DRG is established prospectively by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the United States Department of Health and Human Services ("HHS"), and is not related to a hospital's actual costs. For certain Medicare beneficiaries who have unusually costly hospital stays (referred to as "outliers"), CMS will provide additional payments above those specified for the DRG.

The prospective payment rate is updated annually based upon the hospital "market basket" index, which generally measures changes in the cost of providing health care services. Future adjustments are subject to change by Congress. There is no assurance that these or any future increases in the prospective payment rates will keep pace with the increases in the cost of providing hospital services.

CMS reviews and publishes changes in the DRG classification system at least annually. This process is intended to ensure that each DRG is clinically coherent and represents an acceptable range of resource consumption. There is no assurance that the Alliance will be paid amounts which will reflect adequately changes in the cost of providing health care or in the cost of health care technology being made available to patients.

Costs of Medical Education. Medicare pays for certain direct and indirect costs associated with medical education. Payment for the indirect costs of medical education will be made as an adjustment to the federal rate for capital-related costs during the transition to PPS for inpatient capital-related costs. The indirect medical education adjustment for capital-related costs is based in part on the ratio of a hospital's number of full-time equivalent ("FTE") residents to its average daily census. Medicare also adjusts the inpatient operating PPS payment for indirect costs of medical education. This adjustment is based in part on the ratio of FTE residents to beds. Payment for direct medical education is based on a per resident rate adjusted by inflation and the number of current-year reimbursable resident positions.

Disproportionate Share. Section 402 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) provided for payments to hospitals serving a large number of low-income patients which qualifies them for a Medicare Disproportionate Share ("DSH") payment adjustment. Payment is based on the SSI% plus Medicaid Eligible Patient Days to Total Patient Days. There is no assurance in the future that the Alliance will be paid amounts to adequately offset the cost of providing services to low income patients to Acute and Rehabilitation services.

Costs of Outpatient Services. Ambulatory payment classifications ("APCs") form the basis for outpatient PPS. Services in each APC are similar clinically and with respect to the resources necessary to provide the services. Generally, the primary classification variable under the APC system is the procedure performed rather than the patient's diagnosis, as is the case with the DRG system. Each APC is assigned a payment rate based on median (or, if the Secretary of HHS so chooses, mean) hospital costs for procedures performed, weighted by procedure volume. Beneficiary coinsurance amounts are established for each APC based on 20 percent of the national median of charges for APC services. The APC payment and beneficiary's coinsurance amounts for outpatient services will be adjusted to reflect geographic wage variations and other factors determined to be necessary by the Secretary of HHS. Annual payment updates are based on the hospital market basket index. As with inpatient hospital services,

there is no assurance that future increases in the prospective payment rates will reflect adequately the changes in the costs of providing outpatient services.

Costs of Inpatient Rehabilitation Facilities (IRF). Under IRF PPS, Federal rates are adjusted to reflect patient case mix, resource intensity associated with the patients clinical condition, and facility characteristics. Cases are grouped into case-mix groups (CMGs) and are further classified into 4 tiers driven by conditions that are secondary to the principal diagnosis. Rates are paid to reflect all costs of furnishing IRF services for routine, ancillary, and capital. There is no assurance that the alliance will be paid amounts that will sufficiently match all costs associated with care.

Costs of Psychiatric Facilities (IPF). Under the IPF PPS, services are reimbursed under Federal Per Diem rates to include Operating and Capital costs. Payment is based on Geographic factors, patient characteristics (DRG, age, length of stay and presence of specified comorbidities), facility characteristics, and services for received in a qualified Emergency Department and also Electroconvulsive Therapy.

Costs of Skilled Nursing Facilities. Medicare reimbursed for skilled nursing facility ("SNF") stays are also based on a prospective payment system which requires "bundling" of virtually all SNF services, similar to the current practice for hospital inpatient services. A SNF therefore is responsible for providing or arranging to provide all Medicare services (subject to certain exceptions) needed by a SNF patient, and could potentially receive less than it costs the SNF to provide or arrange to provide those services. Accordingly, there can be no assurance that the aggregate amount of payments under SNF PPS will be sufficient to cover all of the Alliance's actual costs of providing SNF services to Medicare beneficiaries.

Physician Services. Physicians are reimbursed under Medicare based on their professional services according to the lesser of the actual charge or the amount determined from a resource-based relative value scale (RBRVS) fee schedule. The fee schedule is subject to update by the Secretary of HHS and Congress on an annual basis.

Electronic Health Records (EHR) Costs. The American Recovery Act of 2009 provides for incentive payments for Medicare and Medicaid Eligible Professionals and Hospitals to purchase and implement meaningful use certified EHR technology. Payments provide an incentive for the "meaningful use" of certified EHR technology and to achieve health care and efficiency goals. The incentive payment will be paid out over a period of 5 years, which offsets the costs of purchase and implementation of the products. There is no indication that future rule making will extend payments beyond the five years.

Audits, Exclusions, Fines and Enforcement Action. Hospitals participating in Medicare are subject to audits and retroactive audit adjustments by a Medicare Audit Contractor under the Medicare program. From an audit, a Medicare Audit Contractor may conclude, for example, that a patient has been discharged under an incorrect DRG, that services may not have been provided under the direct supervision of a physician (to the extent so required), that a patient should not have been characterized as an inpatient, that certain services provided prior to an admission as an inpatient should not have been billed as outpatient services or that certain required procedures or processes were not satisfied. As a consequence, payments may be retroactively disallowed. Under certain circumstances, payments made may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act or other federal statutes, subjecting the hospital to civil or criminal sanctions. Generally, the Alliance maintains limited reserves for anticipated or proposed audit adjustments which are likely to be contested. Nevertheless, such adjustments may exceed such reserves and may be substantial. Medicare regulations also provide for withholding Medicare payment in certain circumstances, and such withholdings could have a substantial adverse effect on the financial condition of the Alliance.

Management of the Alliance is not aware of any situation in which reserves are inadequate or a material amount of Medicare payments is being withheld. The Alliance utilizes internal and external resources to review and audit practice compliance with policies, procedures, applicable laws and regulations. Whenever such reviews identify practice deviation from policies, procedures, applicable rules and regulations, management is obligated to refund any overpayments as part of the Alliance's continuous improvement processes. Currently, management is unaware of any deviations that may have a material adverse effect on the results of the operations or financial condition of the Alliance.

Commercial Managed Care and Other

The Alliance contracts with certain private third party payors. Contractual agreements with these payors include reimbursement arrangements such as discounted charges, per diem amounts and capitated payments. The Alliance actively manages these contracts and negotiates terms that are in the best interest of the Alliance and its patients. While not participating in all commercial contracts, the Alliance participates in the vast majority of contracts covering the population of its primary service area.

Additionally, the Alliance treats patients with no insurance coverage. Those meeting certain income requirements are treated at no cost to the patient. Those not qualifying for this classification are classified as "self-pay" and reimburse the Alliance privately for the services rendered.

HISTORICAL UTILIZATION INFORMATION

The table below provides a historic system-wide patient utilization for the Alliance for the fiscal years ended June 30, 2007 through 2011. The number reflects the inclusion of the following facilities as of the following dates: Smyth County Community - 11/1/06; Norton Community - 11/1/07; Dickenson Community - 11/1/07; Russell - 1/31/08; and Johnston Memorial - 4/1/09.

	2007	2008	2009	2010	2011
Occupancy Rate (licensed)	46%	49%	45%	46%	47%
Patient Days	246,572	268,965	283,555	291,986	288,167
Admissions	48,055	54,307	57,127	60,102	61,035
Average Daily Census	676	735	777	800	789
Avg Length of Stay (days)	5.1	5.0	5.0	4.9	4.7
Outpatient Visits	953,704	1,239,440	1,511,699	1,604,036	1,590,962
ER Visits	160,972	190,771	219,983	250,942	242,677
Surgical Cases	31,061	35,988	38,812	39,313	39,230
Births	3,849	4,270	4,371	4,684	4,511
Newborn Days	7,616	8,504	8,569	9,112	9,287
Licensed Beds	1,467	1,699	1,841	1,789	1,749

Source: The Alliance.

CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS

The following Condensed Summary of Revenue and Expenses (the "Condensed Summary") for each of the five Fiscal Years ended June 30, 2006 through 2010, is derived from the Alliance's audited financial statements for those Fiscal Years. The annual financial statements were audited by Pershing Yoakley & Associates, P.C. The financial information for the twelve month period ended June 30, 2011, is unaudited and reflects, in the opinion of the Alliance, all adjustments necessary to summarize fairly the results for such period on a basis consistent with that used in preparing the annual financial statements for the years ended June 30, 2006, 2007, 2008, 2009, and 2010. The financial statements include the assets and liabilities and reflect the revenue and expenses of the Alliance and all consolidated entities, including those that are not Obligated Issuers.

The Condensed Summary as well as the audited financial statements included in Appendix B and the unaudited financial statements included as Appendix C are for all entities consolidated with the Alliance for accounting purposes (the "Consolidated Entities") and therefore reflect the assets, liabilities, revenues and expenses of entities that are not Obligated Issuers (see "THE ALLIANCE" in the front half of this Official Statement). For the fiscal year ended June 30, 2011, the Obligated Issuers (excluding the Smyth Corporation and the Norton Corporation, which will not become Obligated Issuers until the issuance of the Series 2011 Bonds) accounted for approximately 83% of the total assets and 75% of the total revenue of the Consolidated Entities.

The following Condensed Summary of Consolidated Revenue and Expenses should be read in conjunction with the audited financial statements and notes contained in Appendix B hereto.

Condensed Summary of Revenue and Expenses

	Audited Fiscal Years Ended June 30 (In Thousands)					(Unaudited) Fiscal Year Ended June 30 (In Thousands)
	2006	2007	2008	2009	2010	2011[9]
Revenues:						
Net patient service revenue	$586,155	$661,744	$726,542	$822,898	$928,270	$960,129
Other revenue	14,969	16,711	16,098	17,046	16,009	15,871
Total Revenue, Gains and Support	601,124	678,455	742,640	839,944	944,279	976,000
Expenses:						
Operating expenses	508,600	580,059	633,842	719,193	804,865	822,435
Depreciation and Amortization	42,702	49,807	60,048	68,523	81,559	90,058
Interest and Taxes	38,230	44,387	44,581	45,225	42,264	45,233
Total Expenses	589,532	674,252	738,471	832,941	928,688	957,726
Operating Income (loss)	11,592	4,203	4,169	7,003	15,591	18,274
Net non-operating gains (losses)[1]	49,320[2]	67,184[3]	(74,343)[4]	(89,683)[5]	29,084[6]	66,809[7]
Excess of Revenue, Gains and Support Over Expenses and Losses[8]	$ 60,912	$ 71,387	$ (70,174)	$ (82,680)	$ 44,675	$ 85,083

Source: The Alliance.

(1) Net non-operating gains and losses include the change in fair value of derivatives and realized and unrealized gains and losses on investments. Recent clarification to generally accepted accounting principles require the unrealized gains and losses on certain investments to be included as part of the Excess of Revenue, Gains and Support over Expenses and Losses and such approach was used for the audited financial statements for fiscal years 2008, 2009, 2010, and unaudited 2011. For ease of comparison, management has reclassified such unrealized gains and losses for fiscal years 2006 and 2007 in a manner consistent with the clarification.

(2) Includes $14.2 million of unrealized gains on derivatives.

(3) Includes $2.1 million of unrealized gains on derivatives.

(4) Includes $20.6 million of unrealized losses on derivatives, and $57.7 million loss on early extinguishment of debt and $33.4 million of unrealized losses on investments.

(5) Includes $42.1 million of unrealized losses on derivatives and $62.6 million of unrealized losses on investments.

(6) Includes $8.6 million of unrealized losses on derivatives, and $15.0 million of unrealized gains on investments.

(7) Includes $21.2 million of unrealized gains on derivatives and $22.2 million of unrealized gains on investments.

(8) An entry was posted in the 2008, 2009, 2010, and 2011 financial statements to eliminate certain employee health related patient service revenue and employee benefits expense (approximately $12.9 million in 2008, $14.9 million in 2009, $20.0 million in 2010, and $23.1 million in 2011). The eliminating entry had no effect on the Excess of Revenue, Gains and Support Over Expenses and Losses in these periods. The 2006 and 2007 financial data does not reflect this eliminating entry.

(9) In Fiscal 2011, the Alliance adopted Financial Accounting Standards Board ASC 350, which requires goodwill be tested for impairment annually. Management is in the process of performing the initial impairment testing on its recorded goodwill, totaling approximately $151.6 million as of June 30, 2011. The unaudited financial results for Fiscal 2011 do not include the impact of goodwill impairment losses, if any, related to the adoption of this standard.

TRENDS IN UNRESTRICTED LIQUIDITY AND LEVERAGE

The following table provides information on unrestricted liquidity and leverage for the fiscal years ended June 30, 2006 through 2011.

	Fiscal 2006	Fiscal 2007	Fiscal 2008	Fiscal 2009	Fiscal 2010	Unaudited Fiscal 2011
Total Unrestricted Cash ($ in Thousands)	$343,946	$452,225	$466,478	$515,066	$551,608	$592,920
Total Days' Cash on Hand	230	264	246	249	240	253
Unrestricted Net Assets ($ in Thousands)	342,777	416,850	349,081	272,049	317,433	399,347
Net Long Term Debt to Capitalization[(1)]	57.7%	53.6%	68.0%[(2)]	74.7%	71.2%	67.6%

(1) For purposes of calculating the ratio, Net Long-Term Debt is determined net of debt service reserve funds and moneys held in principal and interest funds.

(2) The increase in Net Long Term Debt to Capitalization in Fiscal Year 2008 was due in part to the $57.7 million loss on early extinguishment of debt. The Net Long Term Debt to Capitalization, excluding the loss on early extinguishment of debt, was 65.1%.

MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE

Overview

The Alliance has maintained a positive operating income for each of the last six fiscal years, reflecting rises in net patient service revenues that have generally kept pace with increases in expenses. However, non-operating losses from derivatives and other investments resulted in deficits of revenue, gains, and support over expenses for Fiscal 2008 and 2009. The losses from derivatives are discussed further below. The losses from other investments resulted from losses in market value reflecting primarily the general market decline in the value of securities in the Alliance's investment portfolio. Beginning in Fiscal 2007, operating income or losses for recent acquisitions is included (Fiscal 2007: Smyth County - 8 months, Fiscal 2008: Norton/Dickenson – 8 months and Russell 5 months, Fiscal 2009: Johnston Memorial – 3 months).

Fiscal 2009

The Operating Income for Fiscal 2009 was $7.003 million, reflecting increases in net patient service revenue and expenses resulting primarily from the addition of Johnston Memorial Hospital in April, 2009. This resulted in an Operating Margin (net operating income as a percentage of total operating revenue) of 0.8%. However, an overall loss, i.e. an excess of expenses and losses over revenue, gains and support, resulted from net non-operating losses totaling $89.683 million. The non-operating losses reflected primarily (1) $62.582 million of unrealized losses on investments and (2) $42.128 million of losses derived from interest rate swaps and derivatives, as discussed below in "Interest Rate Swaps and Derivatives." Such losses resulted in a deficit of revenue, gains, and support over expenses of $82.680 million.

Fiscal 2010

The Operating Income for Fiscal 2010 was $15.591 million compared with $7.003 million for the same period in Fiscal 2009. The Operating Margin for Fiscal, 2010 was 1.7%, compared with 0.8% for the same period in Fiscal 2009. This reflected among other things increases in revenues and expenses resulting from the addition of Johnston Memorial (April, 2009) that are included for a full year in the Fiscal 2010 but included for only three months in Fiscal 2009. Moreover, net non-operating gains of $29.084 million, reflecting primarily $24.083 million of income realized from investments, $15.018 million of unrealized income from investments, and $8.607 million in losses derived from interest rate swaps and derivatives, produced a $44.675 million excess of revenue, gains and support over expenses.

Fiscal 2011

The Operating Income for Fiscal 2011 was $18.274 million compared with $15.591 million for the same period in Fiscal 2010. The Operating Margin for Fiscal 2011 was 1.9%, compared with 1.7% for the same period in Fiscal 2010. Moreover, net non-operating gains of $66.809 million, reflecting primarily $23.216 million of income realized from investments, $22.168 million of unrealized income from investments, and $21.165 million in gains derived from interest rate swaps and derivatives, produced a $85.083 million excess of revenue, gains and support over expenses.

Interest Rate Swaps and Derivatives

The Alliance has utilized several forms of derivative financial instruments, including interest rate swaps, constant maturity swaps, total return swaps and swaptions, in order to lower the cost of debt and reduce interest rate risk.

As of August 31, 2011, the Alliance had a total of approximately $592,400,000 (notional amount) of total return swaps, basis swaps, and constant maturity basis swaps with Bank of America, which swaps have been implemented as part of a carefully managed program. Through this program, the Alliance has realized approximately $37,400,000 of savings since 2001. In January and May of 2011, the Alliance "locked in" approximately $16,000,000 of future cash payments through April 2014 on $438,000,000 (notional amount) of the constant maturity basis swaps. In January 2011, the Alliance converted two fixed payor swaps, totaling $132,000,000 (notional amount), to basis swaps. As of August 31, 2011, the market value of all these swaps was ($14,200,000). The amount of collateral posted to Bank of America, as of August 31, 2011, was $330,000. Funds that have been posted as collateral are not included in the reporting of unrestricted cash and investments.

In August 2011, the Alliance entered into two forward starting interest rate swaps with Bank of America, totaling $96,800,000 (notional amount). The counterparties expect that the swaps will terminate on or about November 4, 2011 and May 3, 2012 with any related termination payment to be made by the owing party on or about January 1, 2012 and July 1, 2012 respectively. As of August 31, 2011, the market value of these swaps was $282,000.

Additionally, the Alliance has $106,000,000 (notional amount) of total return and fixed payor swaps with Lehman Brothers Special Financing, Inc. ("Lehman"). As of August 31, 2011, the Alliance had posted $13,800,000 of collateral under the Lehman swap agreements. In the Fall of 2008, the Alliance was notified by Lehman that these transactions were going to be terminated as of January 1, 2009. The termination did not occur, due to a dispute between counterparties regarding the amount of the cost of the termination. The Alliance believes that the amount of the collateral that has been posted is sufficient to pay the cost of the termination. In late 2011 or 2012, the counterparties may schedule a mediation to settle the termination amount.

In 2003 and 2004, the Alliance implemented $224,400,000 (notional amount) of swaptions with Bear Stearns Capital Markets, now J.P. Morgan, as part of a synthetic refunding of its Series 2000 outstanding debt. Amounts received by the Alliance as upfront payments on the swaptions and related forward sale agreements were deposited in a guaranteed investment contract ("GIC") with Bear Stearns, now J.P. Morgan, that served as collateral under the related agreements. On October 13, 2011, the Alliance terminated the swaptions using the entire proceeds of the GIC. No additional funds of the Alliance were utilized. The forward sale agreements remain in place. As of August 31, 2011, the mark-to-market of the forward sale agreements with J.P. Morgan was ($15,891,644). The Alliance is required to post collateral to J.P. Morgan only if the total mark-to-market exposure exceeds $17,500,000.

Additional Indebtedness

The Alliance has several significant capital expenditures planned or in process for the near future. Some of the larger projects include a new surgical services facility at JCMC. Funding for these projects is expected to come from cash flow and the proceeds of this and a future revenue bond issue.

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APPENDIX B

AUDITED CONSOLIDATED FINANCIAL STATEMENTS FOR FISCAL YEARS ENDED JUNE 30, 2010 AND 2009

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MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements
(and Supplemental Schedules)

Years Ended June 30, 2010 and 2009

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Schedules)

Years Ended June 30, 2010 and 2009

PYA
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CERTIFIED PUBLIC ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited the accompanying consolidated balance sheets of Mountain States Health Alliance and subsidiaries (the Alliance) as of June 30, 2010 and 2009 and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Alliance's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mountain States Health Alliance and subsidiaries as of June 30, 2010 and 2009 and the results of their operations, changes in net assets and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The supplemental schedules, as listed in the accompanying index, are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Knoxville, Tennessee
October 25, 2010

Pershing Yoakley & Associates, P.C.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2010	2009
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	**$ 234,526**	$ 239,836
Current portion of investments	**28,467**	27,317
Patient accounts receivable, less estimated allowances for uncollectible accounts of $45,941 in 2010 and $42,587 in 2009	**125,580**	128,812
Other receivables, net	**17,926**	16,108
Inventories and prepaid expenses	**29,163**	27,135
TOTAL CURRENT ASSETS	**435,662**	439,208
INVESTMENTS, less amounts required to meet current obligations	**586,756**	597,440
PROPERTY, PLANT AND EQUIPMENT, net	**695,598**	590,569
OTHER ASSETS		
Goodwill, net of accumulated amortization of $95,760 in 2010 and $84,687 in 2009	**151,352**	162,620
Net deferred financing, acquisition costs and other charges, less current portion	**30,819**	31,473
Other assets	**29,313**	34,765
TOTAL OTHER ASSETS	**211,484**	228,858
	$ 1,929,500	$ 1,856,075

	June 30, 2010	June 30, 2009
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	$ **16,039**	$ 12,050
Current portion of long-term debt and capital lease obligations	**28,131**	31,306
Current portion of estimated fair value of derivatives	**10,740**	10,921
Accounts payable and accrued expenses	**99,227**	94,712
Accrued salaries, compensated absences and amounts withheld	**47,280**	49,569
Estimated amounts due to third-party payors, net	**10,155**	6,398
TOTAL CURRENT LIABILITIES	**211,572**	204,956
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	**1,054,842**	1,040,944
Estimated fair value of derivatives, less current portion	**123,560**	115,296
Deferred revenue	**20,445**	21,078
Estimated professional liability self-insurance	**9,541**	10,012
Other long-term liabilities	**12,628**	13,885
TOTAL LIABILITIES	**1,432,588**	1,406,171
MINORITY INTERESTS	**168,410**	165,500
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and N		
NET ASSETS		
Unrestricted net assets	**317,434**	272,049
Temporarily restricted net assets	**10,941**	12,178
Permanently restricted net assets	**127**	177
TOTAL NET ASSETS	**328,502**	284,404
	$ **1,929,500**	$ 1,856,075

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

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

	Year Ended June 30, 2010	2009
CHANGES IN UNRESTRICTED NET ASSETS:		
Revenue, gains and support:		
Net patient service revenue	$ **928,270**	$ 822,898
Other operating revenue	**16,009**	17,046
TOTAL REVENUE, GAINS AND SUPPORT	**944,279**	839,944
Expenses:		
Salaries and wages	**325,663**	296,073
Physician salaries and wages	**54,489**	38,240
Contract labor	**6,546**	16,899
Employee benefits	**68,362**	61,134
Fees	**82,542**	71,896
Supplies	**175,469**	156,418
Utilities	**16,193**	15,548
Other	**67,640**	57,974
Depreciation	**68,436**	56,373
Amortization	**13,123**	12,150
Estimated provision for bad debts	**7,961**	5,011
Interest and taxes	**42,264**	45,225
TOTAL EXPENSES	**928,688**	832,941
OPERATING INCOME	**15,591**	7,003
Nonoperating gains (losses):		
Interest and dividend income	**17,298**	19,105
Net realized gains (losses) on the sale of securities	**2,385**	(6,552)
Net unrealized gains (losses) on securities	**15,018**	(62,582)
Derivative related income	**4,394**	4,772
Loss on termination of derivatives - Note D	**-**	(2,785)
Loss on early extinguishment of debt - Note F	**(3,029)**	-
Change in estimated fair value of derivatives	**(8,607)**	(42,128)
Other nonoperating gains (losses)	**512**	(306)
Net assets released from restrictions used for operations	**1,113**	793
NET NONOPERATING GAINS (LOSSES)	**29,084**	(89,683)

	Year Ended June 30, 2010	2009
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES, BEFORE DISCONTINUED OPERATIONS AND MINORITY INTERESTS	**44,675**	(82,680)
Gain on sale of and deficit of revenue, gains and support over expenses and losses from discontinued operations	**-**	2,519
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES BEFORE MINORITY INTERESTS	**44,675**	(80,161)
Minority interest in consolidated subsidiaries' net (gain) loss	**(3,162)**	546
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	**41,513**	(79,615)
Other changes in unrestricted net assets:		
Pension and other defined benefit plan adjustments	**1,589**	(512)
Net assets released from restrictions used for the purchase of property, plant and equipment	**2,283**	3,095
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	**45,385**	(77,032)
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS:		
Restricted grants and contributions	**2,159**	3,929
Net assets released from restrictions	**(3,396)**	(3,888)
(DECREASE) INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	**(1,237)**	41
CHANGES IN PERMANENTLY RESTRICTED NET ASSETS:		
Net assets released from restrictions by donor	**(50)**	-
INCREASE (DECREASE) IN TOTAL NET ASSETS	**44,098**	(76,991)
NET ASSETS, BEGINNING OF YEAR	**284,404**	361,395
NET ASSETS, END OF YEAR	**$ 328,502**	$ 284,404

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	Year Ended June 30,	
	2010	*2009*
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase (decrease) in net assets	**$ 44,098**	$ (76,991)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	**81,982**	68,967
Loss on early extinguishment of debt	**3,029**	-
Loss on termination of derivatives	**-**	3,245
Change in estimated fair value of derivatives	**8,607**	42,128
Equity in net income of joint ventures	**(1,117)**	(723)
Gain on sale of assets held for resale and disposal of assets	**(548)**	(568)
Amounts received on interest rate swap settlements	**(4,394)**	(4,772)
Minority interest in consolidated subsidiaries' net (gain) loss	**3,162**	(546)
Income recognized through forward sale agreements	**(864)**	(796)
Capital Appreciation Bond accretion and other	**2,071**	1,678
Restricted contributions	**(2,159)**	(3,929)
Pension and other defined benefit plan adjustments	**598**	512
Increase (decrease) in cash due to change in:		
Net patient accounts receivable	**3,232**	724
Other receivables, net	**(1,246)**	(4,107)
Inventories and prepaid expenses	**(4,640)**	1,843
Trading securities	**(13,368)**	183,450
Other assets	**(1,159)**	(4,144)
Accrued interest payable	**3,989**	1,900
Accounts payable and accrued expenses	**(855)**	8,551
Accrued salaries, compensated absences and amounts withheld	**(2,289)**	3,500
Estimated amounts due from/to third-party payors, net	**3,757**	6,492
Other long-term liabilities	**(201)**	(1,363)
Estimated professional liability self-insurance	**(471)**	(610)
Total adjustments	**77,116**	301,432
NET CASH PROVIDED BY OPERATING ACTIVITIES	**121,214**	224,441
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment, property held for resale and property held for expansion, net	**(172,240)**	(119,741)
Additions to goodwill	**-**	(16,097)
Net decrease (increase) in assets limited as to use	**50,362**	(28,152)
Purchases of held-to-maturity securities	**(28,175)**	-
Net sale or distribution from joint ventures and unconsolidated affiliates	**1,162**	384

	Year Ended June 30, 2010	2009
Proceeds from sale of property, plant and equipment and property held for resale	9,565	2,056
NET CASH USED IN INVESTING ACTIVITIES	(139,326)	(161,550)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(226,315)	(36,820)
Payment of acquisition and financing costs	(3,565)	(3,214)
Proceeds from issuance of long-term debt and other financing arrangements	235,158	135,780
Net amounts received on interest rate swap settlements	4,394	4,772
Restricted contributions received	3,382	5,767
Distribution to minority shareholders and other	(252)	(158)
NET CASH PROVIDED BY FINANCING ACTIVITIES	12,802	106,127
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(5,310)	169,018
CASH AND CASH EQUIVALENTS, beginning of year	239,836	70,818
CASH AND CASH EQUIVALENTS, end of year	$ 234,526	$ 239,836

SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:		
Cash paid for interest	$ 38,666	$ 45,218
Cash paid for federal and state income taxes	$ 446	$ 664
Construction related payables in accounts payable and accrued expenses	$ 14,847	$ 9,246
Increase in receivable from sale of property	$ 1,483	$ -
Decrease in land held for expansion related to property exchange transaction	$ 3,432	$ -

During the years ended June 30, 2010 and 2009, the Alliance refinanced previously issued debt of $184,050 and $9,445, respectively.

As discussed in Note A, the Alliance acquired a 50.1% interest in Johnston Memorial Hospital, Inc. (JMH) in fiscal year 2009. JMH is consolidated within the accompanying financial statements as of the acquisition date, April 1, 2009. The consolidated cash flows include JMH's cash flows since the acquisition date.

(Dollars in Thousands)

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions. Membership of the Alliance consists of individuals and institutions who have contributed at least $100 to the capital fund of the Alliance and are entitled to vote at the annual election of the Board of Directors.

The primary operations of the Alliance consist of eleven acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 645 beds
- Indian Path Medical Center (IPMC) - licensed for 322 beds
- Smyth County Community Hospital (SCCH) - licensed for 279 beds
- Johnston Memorial Hospital (JMH) - licensed for 135 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- North Side Hospital (NSH) - licensed for 91 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Johnson City Specialty Hospital (JCSH) - licensed for 23 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

Effective April 1, 2009, the Alliance acquired an interest in Johnston Memorial Hospital, Inc. (JMH), a 135 bed general acute care hospital located in Abingdon, Virginia. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices. The Alliance acquired a 50.1% interest in JMH by providing $132,000 to JMH (designated for capital). Johnston Memorial Healthcare Foundation, Inc. (JMHF), a hospital supporting organization, retained a 49.9% interest in JMH. The assets and liabilities of JMH at April 1, 2009 have been consolidated by the Alliance at their carrying value as of that date. The following is condensed, unaudited financial information related to JMH as of March 31, 2009:

Current Assets	$	23,516
Other Assets		139,576
Total	$	163,092
Liabilities	$	47,440
Net Assets (initial membership interest of JMHF)		115,652
	$	163,092

NOTE A--ORGANIZATION AND OPERATIONS - Continued

The activities and accounts of JMH since April 1, 2009 are included in the accompanying consolidated financial statements.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and; Community Home Care (CHC), a taxable corporation that provides home medical equipment. The activities and accounts of NCH are included in the accompanying consolidated financial statements.

The Alliance also has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services. The activities and accounts of SCCH are included in the accompanying consolidated financial statements.

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following organizations:

Blue Ridge Physician Group, Inc. (BRPG): A company that contracts with physicians to provide services to BRMM physician practices.

Mountain States Properties, Inc. (MSPI): An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services. In addition, MSPI is a counter-party to various financing transactions, including interest rate swaps.

Mediserve Medical Equipment of Kingsport, Inc. (Mediserve): A company that provides durable medical equipment services.

Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery): A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC at June 30, 2010 and 2009; however, BRMM maintains control over KASC. As such, the accounts and activities of KASC are included in the accompanying consolidated financial statements.

NOTE A--ORGANIZATION AND OPERATIONS - Continued

Piney Flats Urgent Care (PFUC): A for-profit entity that provides urgent care patient services.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

Prior to 2010, the Alliance was a majority shareholder of PHP of Tri-Cities, LLC (PHPT). PHPT's primary purpose was to hold an equity interest in another organization engaged in and related to the financing and/or delivery of healthcare services. During 2009, PHPT's equity interest in this other entity was reacquired by that entity (PHP Companies, Inc. (PHP)). PHPT sold the interest to PHP for a net gain of $2,519. The activities of PHPT and gain on sale are included in the accompanying 2009 consolidated financial statements as "discontinued operations". During 2009, PHPT was reorganized under the business name of Integrated Solutions Health Network, LLC (ISHN). Concurrent with the reorganization, the Alliance purchased the remaining ownership interest of Health Alliance PHO, Inc. (PHO), an entity in which the Alliance previously held a minority interest. The net assets of the PHO were merged into ISHN on June 30, 2009. The primary function of ISHN is to establish, operate and administer a provider-sponsored health care delivery network.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its subsidiaries after elimination of all significant intercompany accounts and transactions. The Alliance classifies those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities.

A minority interest is recorded to recognize the ownership or membership interests of third parties with respect to JMH, NCH, SCCH, KASC, PFUC and ISHN.

In 2011, the Alliance will adopt recently issued accounting standards, which change the accounting for, and the financial statement presentation of, noncontrolling interests in a subsidiary within consolidated financial statements. This new standard requires that a noncontrolling interest in the equity of a subsidiary be accounted for and reported as equity, provides revised guidance on the treatment of net income and losses attributable to the noncontrolling interest and changes in ownership interests in a subsidiary and requires additional disclosures that identify and distinguish between the interests of the controlling and noncontrolling owners. Management of the

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Alliance is currently assessing the potential impact of the adoption of this new guidance on the consolidated financial statements.

Use of Estimates: The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from these estimates.

Accounting Standards Codification: In June 2009, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standard (SFAS) No. 168, *The FASB Accounting Standards Codification and the Hierarchy of Generally Accepted Accounting Principles (GAAP) - a Replacement of FASB Statement No. 162.* This Statement modifies the GAAP hierarchy by establishing only two levels of GAAP, authoritative and nonauthoritative literature. Effective September 2009, the FASB Accounting Standards Codification (ASC), also known collectively as the "Codification," is considered the single source of authoritative U.S. accounting and reporting standards. FASB ASC 105-10, Generally Accepted Accounting Principles, became applicable during fiscal year 2010. All accounting references have been updated, and therefore SFAS references have been replaced with ASC references. The adoption of the ASC did not have an impact on the consolidated financial statements.

Cash and Cash Equivalents: Cash and cash equivalents include all highly liquid investments with a maturity of three months or less when purchased. Cash and cash equivalents designated as assets limited as to use or uninvested amounts included in investment portfolios are not included as cash and cash equivalents on the Consolidated Balance Sheets.

Investments: Investments as reported in the Consolidated Balance Sheets includes trading securities, held-to-maturity securities and assets limited as to use (Note C). FASB ASC 958-320, *Investments – Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments (including assets limited as to use) are considered as trading securities. Management annually evaluates the held-to-maturity investment portfolio and recognizes any "other-than-temporary" losses as deductions from the Performance Indicator. Management's evaluation considers the amount of decline in fair value, as well as the time period of any such decline. Management does not believe any investment classified as held-to-maturity is other-than-temporarily impaired at June 30, 2010.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Within the trading securities portfolio, all debt securities and marketable equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investments without readily determinable fair values are reported at fair market value pursuant to FASB ASC 825, *Financial Instruments*. Guaranteed investment contracts are reported at contract value.

Realized gains and losses on trading securities and assets limited as to use are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of $2,418 and $2,463 at June 30, 2010 and 2009, respectively.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

Property, Plant and Equipment: Property, plant and equipment is stated on the basis of cost, or if donated, at the fair value at the date of gift. Generally, depreciation is computed by the straight-line method over the estimated useful life of the asset. Equipment held under capital lease obligations is amortized under the straight-line method over the shorter of the lease term or estimated useful life. Amortization of equipment held under capital lease is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

The Alliance reviews capital assets for indications of potential impairment when there are changes in circumstances related to a specific asset. If this review indicates that the carrying value of these assets may not be recoverable, the Alliance estimates future cash flows from operations and the eventual disposition of such assets. If the sum of these undiscounted future cash flows is less than the carrying amount of the asset, a write-down to estimated fair value is recorded. The Alliance did not recognize any impairment losses during 2010 and 2009.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

Property held for resale and property held for expansion primarily represent land contributed to, or purchased by, the Alliance plus costs incurred to develop the infrastructure of such land. Other assets include property held for resale and property held for expansion of $9,135 and $12,542, respectively, at June 30, 2010 and 2009. Management annually evaluates its investment and records non-temporary declines in value when it is determined the ultimate net realizable value is less than the recorded amount. No such declines were identified in 2010 and 2009.

Goodwill: Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. The Alliance amortizes goodwill associated with its not-for-profit subsidiaries under the straight-line method over various estimated useful lives. For goodwill acquired by its for-profit subsidiaries, the Alliance does not amortize the goodwill and annually performs impairment testing in accordance with FASB ASC 350, *Intangibles – Goodwill and Other*. At June 30, 2010, management does not believe any goodwill so tested to be impaired.

FASB ASC 350, *Intangibles - Goodwill and Other,* will require, among other things, that goodwill associated with not-for-profit entities be evaluated annually for impairment, including a transitional impairment test upon adoption, and that such goodwill no longer be amortized. The Alliance will be required to adopt this standard in 2011 and will perform such transitional testing as of July 1, 2010 prior to December 31, 2010. While the Alliance is evaluating the potential impact of the adoption of this standard, including the transitional impairment testing, it is currently not possible to determine the effects, if any, the adoption of this standard will have on the consolidated financial statements.

Deferred Financing, Acquisition Costs and Other Charges: Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Beginning in 2009, interest rate swap and derivative transaction issuance costs are expensed as incurred, in accordance with FASB ASC 820, *Fair Value Measurements and Disclosures* (FASB ASC 820). No such costs were incurred in 2010 and 2009.

Derivative Financial Instruments: As further described in Note D, the Alliance is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

and have been presented at estimated fair market value in the accompanying Consolidated Balance Sheets. These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) and are recorded at the estimated net present value of such claims. Other long-term liabilities include contributions payable and obligations under deferred compensation arrangements, a defined benefit pension plan, a post-retirement employee benefit plan as well as other liabilities which management estimates are not payable within one year.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The Alliance's revenue recognition policies related to self-pay and other types of payors emphasize revenue recognition only when collections are reasonably assured.

Patient accounts receivable are reported net of both an estimated allowance for uncollectible accounts and an estimated allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, TennCare and other third-party payment programs. Current operations include a provision for bad debts in the Consolidated Statements of Operations and Changes in Net Assets estimated based upon the age of the patient accounts receivable, prior experience and any unusual circumstances (such as local, regional or national economic conditions) which affect the collectibility of receivables, including management's assumptions about conditions it expects to exist and courses of action it expects to take.

The Alliance's policy does not require collateral or other security for patient accounts receivable. The Alliance routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies.

Charity Care: The Alliance accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Alliance and various guidelines outlined by the Federal Government. These policies define charity as those services for

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

which no payment is anticipated and, as such, charges at established rates are not included in net patient service revenue.

In addition to the charity care services described above, the Alliance provides a number of other services to benefit the poor for which little or no payment is received. Medicare, TennCare and State indigent programs do not cover the full cost of providing care to beneficiaries of those programs. The Alliance also provides services to the community at large for which it receives little or no payment.

Excess (Deficit) of Revenue, Gains and Support Over Expenses and Losses: The Consolidated Statements of Operations and Changes in Net Assets includes the caption *Excess (Deficit) of Revenue, Gains and Support Over Expenses and Losses* (the Performance Indicator). Changes in unrestricted net assets which are excluded from the Performance Indicator, consistent with industry practice, include transfers of assets to and from affiliates and contributions of long-lived assets or amounts restricted to the purchase of long-lived assets, as well as pension and related adjustments.

Income Taxes: The Alliance is classified as an organization exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. As such, no provision for income taxes has been made in the accompanying consolidated financial statements for the Alliance and its tax-exempt subsidiaries. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income Taxes* (Note L). The Alliance has no significant uncertain tax positions at June 30, 2010 and 2009.

Temporarily and Permanently Restricted Net Assets: Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. When a donor or time restriction expires; that is, when a stipulated time restriction ends or purpose restriction is fulfilled, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the Statements of Operations and Changes in Net Assets as net assets released from restrictions. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Fair Value Measurement: In 2009, the Hospital adopted FASB ASC 820, *Fair Value Measurements and Disclosures,* which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements. There was no significant impact on the consolidated financial statements as a result of adopting this standard (Note Q).

(Dollars in Thousands)

NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued

In January 2010, the FASB issued ASU 2010-06, *Fair Value Measurements and Disclosures (Topic 820) - Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 requires new disclosures regarding significant transfers in and out of Levels 1 and 2, as well as information about activity in Level 3 fair value measurements, including presenting information about purchases, sales, issuances and settlements on a gross versus a net basis in the Level 3 activity roll forward. In addition, ASU 2010-06 clarifies existing disclosures regarding input and valuation techniques, as well as the level of disaggregation for each class of assets and liabilities. The Alliance will adopt ASU 2010-06 in 2011, except for the disclosures related to purchases, sales, issuance and settlements, which will be effective for the Alliance beginning July 1, 2012. The adoption of ASU 2010-06 is not expected to have an impact on the Alliance's consolidated financial statements.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2010, through October 25, 2010, the issuance date of the consolidated financial statements. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2010 consolidated financial statements, other than as discussed in Note D and in Note F.

Reclassifications: Certain 2009 amounts have been reclassified to conform with the 2010 presentation in the accompanying consolidated financial statements.

NOTE C--INVESTMENTS

Assets limited as to use are summarized by designation or restriction as follows at June 30:

	2010	*2009*
Designated or restricted:		
Under safekeeping agreements	$ 52,050	$ 40,604
Under guarantee agreements	89,486	86,364
By Board for capital improvements	2,776	-
Under bond indenture agreements:		
For debt service and interest payments	78,612	60,828
For capital acquisitions	76,241	161,731
	299,165	349,527
Less: amount required to meet current obligations	(25,092)	(22,492)
	$ 274,073	$ 327,035

(Dollars in Thousands)

NOTE C--INVESTMENTS- Continued

Assets limited as to use consist of the following at June 30:

	2010	2009
Cash, cash equivalents and money market funds	$ 170,897	$ 173,859
U.S. Government securities	1,795	1,795
U.S. Agency securities	12,319	18,827
Guaranteed investment contracts	114,154	155,046
	$ 299,165	$ 349,527

Trading securities consist of the following at June 30:

	2010	2009
Cash, cash equivalents and money market funds	$ 4,799	$ 14,622
U.S. Government securities	3,137	-
U.S. Agency securities	13,760	16,013
Corporate and foreign bonds	15,063	10,014
Municipal obligations	1,461	3,101
U.S. equity securities	142,816	161,284
Other	28,608	30,031
	209,644	235,065
Less: amount classified as current	(3,375)	(4,825)
	$ 206,269	$ 230,240

Held-to-Maturity securities consist of the following at June 30:

	2010	2009
Cash, cash equivalents and money market funds	$ 1,131	$ 452
Corporate and foreign bonds	103,968	39,504
Municipal obligations	1,315	209
	$ 106,414	$ 40,165

Held-to-maturity securities had gross unrealized gains and losses of $5,525 and $607, respectively, at June 30, 2010 and $831 and $110, respectively at June 30, 2009. At June 30, 2010, the Alliance held one security within the held-to-maturity portfolio with a fair value and unrealized loss of $591

NOTE C--INVESTMENTS- Continued

and $166, respectively, which had been at an unrealized loss position for over one year. At June 30, 2009, no securities held in the held-to-maturity portfolio had been in an unrealized loss position for over one year. At June 30, 2010, the contractual maturities of held-to-maturity securities were $13,389 due in one year or less, $48,447 due from one to five years and $44,578 due after five years. At June 30, 2009, the contractual maturities of held-to-maturity securities were $733 due in one year or less, $21,190 due from one to five years and $18,242 due after five years.

At June 30, 2010 and 2009, the Alliance held investments in certain limited partnerships and hedge funds of $28,608 and $30,031, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at fair market value pursuant to FASB ASC 825, *Financial Instruments*.

The Alliance has investments in several joint ventures and corporations which are accounted for under the equity method of accounting.

As a part of the acquisition of membership interests in JMH, SCCH and NCH, the Alliance has committed to invest $132,000, $48,100, and $45,000, respectively. Cumulative amounts expended at June 30, 2010 under these commitments are approximately $73,600.

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and, as such, are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance.

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. Such investments are included as assets limited as to use. As of June 30, 2010, management believes the Alliance was fully collateralized with respect to the derivative agreements and management does not believe such collateral is exposed to third-party credit risk. Further, certain of the agreements contain requirements regarding maintenance of financial and liquidity ratios. Management has represented the Alliance is in compliance with all such covenants at June 30, 2010.

Interest Rate Swaps: The Alliance is a party to six interest rate swap agreements with Merrill Lynch as the counterparty. A liability, representing the estimated fair value of these swaps, of $33,910 and $37,274 was recognized by the Alliance as of June 30, 2010 and 2009, respectively.

(Dollars in Thousands)

NOTE D--DERIVATIVE TRANSACTIONS - Continued

The following is a summary of five of these interest rate swap agreements at June 30, 2010:

Swap	*Notional Amount*	*Term*	*Payments by:*	
			Counterparty	*Alliance*
A	$ 170,000	4/2008-4/2026	0.51% through April 2011, then 71.10% of USD-ISDA Swap Rate	0.00% through April 2011, then USD-SIFMA Municipal Swap Index
B	95,000	4/2008-4/2026	0.52% through April 2011, then 71.18% of USD-ISDA Swap Rate	0.00% through April 2011, then USD-SIFMA Municipal Swap Index
C	173,030	4/2008-4/2034	0.53% through April 2011, then 72.35% of USD-ISDA Swap Rate	0.00% through April 2011, then USD-SIFMA Municipal Swap Index
D	82,055	12/2007-7/2033	USD-LIBOR-BBA through June 2012, then 67.00% USD-LIBOR-BBA	4.411% through June 2012, then 3.805%
E	50,000	2/2008-7/2038	67.00% of USD-LIBOR-BBA less 0.07%	3.41%

Deferred financing and acquisition costs, net of amortization, include $6,823 and $7,167 at June 30, 2010 and 2009, respectively, related to these swaps.

In addition to the swaps described above, the Alliance and Merrill Lynch are also parties to a total return swap in the notional amount of $23,900. No deferred financing and acquisition costs were recorded as a result of this transaction. The agreement consists of the following:

- An agreement that requires the Alliance to pay a variable rate of USD-SIFMA Municipal Swap Index through July 1, 2012 (or termination of the swap) on a notional amount equal to the outstanding 2001A Hospital Revenue and Improvement Bonds (the 2001A Reference Bonds). The Alliance receives a fixed rate of 6.25% on the outstanding 2001A Reference Bonds.

- A "total return provision" under which the Alliance will pay (or receive) an amount equal to the product of the outstanding 2001A Reference Bonds multiplied by the difference between the outstanding 2001A Reference Bonds and the 2001A Reference Bonds' market price at termination, as defined in the agreement. In the event the swap does not terminate prior to July 1, 2012, there would be no settlement of this component as there would be no outstanding 2001A Reference Bonds.

NOTE D--DERIVATIVE TRANSACTIONS - Continued

During 2009, the Alliance terminated an interest rate swap with a notional amount of $318,315 to which Merrill Lynch was the counterparty. As a result of the termination, the Alliance wrote-off deferred financing and issuance costs of $3,220 and recognized a gain on termination of $3,054, which are included in loss on termination of derivatives in the accompanying 2009 Consolidated Statement of Operations and Changes in Net Assets.

The Alliance is party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. As of October 25, 2010, the Alliance and Lehman Brothers Special Financing, Inc. have been unable to reach a settlement agreement. In September 2010, the Alliance was issued a subpoena to furnish certain documentation related to the transaction. A protocol has been put into place by the bankruptcy court whereby the parties are to undergo alternate dispute resolution. If a settlement is not reached through the alternate dispute resolution process, the matter will be subject to non-binding arbitration. Legal counsel has advised management that the court ordered process may take several years.

The fair value of these swaps is undeterminable at January 1, 2009, as prior to the termination date Lehman Brothers liquidated the underlying referenced securities, making a valuation not commercially viable. An estimated liability of $10,740 and $10,921 was recognized by the Alliance as of June 30, 2010 and 2009, respectively. Management believes that the liability as recorded at June 30, 2010 is sufficient to cover any exposure arising from litigation in this matter. However, it is reasonably possible management's estimate may change in the near term, although the amount of any change cannot be estimated. Due to the termination of this agreement, the estimated liability is included as a current liability in the accompanying Consolidated Balance Sheets.

A third party holds collateral with a fair market value of approximately $13,570 and $13,252, respectively, at June 30, 2010 and 2009, with respect to these derivative agreements. Such collateral is included as current assets limited as to use. Additionally, during 2009 the Alliance wrote-off deferred financing and issuance costs related to these swaps of $2,619 which is included in loss on termination of derivatives in the accompanying 2009 Consolidated Statement of Operations and Changes in Net Assets.

The arrangement consists of nine agreements each with three separate components (described below) with notional values of $23,600, $8,000, and $8,750 each. The swaps generally consist of the following:

NOTE D--DERIVATIVE TRANSACTIONS - Continued

- An arrangement that calls for the Alliance to pay a variable rate (SIFMA Municipal Swap Index) plus certain fixed payment amounts and receive a payment equal to the interest paid by the Alliance on a portion of its early extinguished, but still outstanding, 2000A and 2000B Hospital Mortgage Revenue Refunding Bonds (the Reference Bonds) (whose fixed rates range from 7.50% to 7.75%).

- An arrangement that requires the Alliance to pay a fixed rate of 4.211% through either July 1, 2025, 2029 or 2033 (or termination of the swap) on the outstanding Reference Bonds and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding Reference Bonds; and

- A "total return provision" under which the Alliance will pay (or receive) the difference between the outstanding Reference Bonds, multiplied by 132%, less the fair value of the Reference Bonds on the date of termination and any fixed interest payments made under the arrangements described above. In the event the swaps do not terminate prior to their stated termination dates (2025, 2029 or 2033), there would be no settlement of this component as there would be no outstanding Reference Bonds.

The swap also contains an agreement that consists of two separate components:

- An arrangement that requires the Alliance to pay a fixed rate of 2.98% through July 1, 2016 (or termination of the swap) on the outstanding, but previously defeased, 1991 Hospital Revenue and Improvement Bonds (the 1991 Reference Bonds) and receive a variable rate of 67% of USD-LIBOR-BBA on the outstanding 1991 Reference Bonds; and

- A "fixed payor provision" under which the Alliance will pay (or receive) the difference between the outstanding 1991 Reference Bonds multiplied by 100% and any fixed interest payments made as required under the agreement minus the outstanding 1991 Reference Bonds multiplied by the average market price at termination. In the event the swaps do not terminate prior to their stated termination date (2016), there would be no settlement of this component as there would be no outstanding 1991 Reference Bonds.

Interest Rate Swap Option: In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns has purchased from the Alliance an option to enter into an interest rate swap agreement (swaption) with the Alliance on July 1, 2011, which is an optional redemption date related to the Alliance's early extinguished 2000A and 2000B Bonds (Note F). The purpose of this agreement was to effectively sell the call features related to the early extinguished Series 2000A and 2000B Bonds. As consideration under this agreement, the Alliance

(Dollars in Thousands)

NOTE D--DERIVATIVE TRANSACTIONS - Continued

received a total of $42,500 in upfront payments as the swaption premium. Such amounts were initially recorded as estimated fair value of derivatives in the Consolidated Balance Sheets. Beginning 30 calendar days prior to July 1, 2011 and terminating 30 calendar days prior to July 1, 2015, the counterparty has the periodic right to exercise the swaption.

The underlying interest rate swap transactions to which the swaption transaction relates have the following terms:

Swap	*Notional Amount*	*Term*	*Payments by:*	
			Counterparty	*Alliance*
2000A	Ranging from $148,170 through July 1, 2018 to $23,000 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.13% upon execution to 7.50% through July 2033, based on notional amount
2000B	Ranging from $76,240 through July 1, 2021 to $8,800 through July 2033	30 days following the exercise date through July 2033	64% of USD-LIBOR-BBA	Fixed amounts ranging from 7.54% upon execution to 8.00% through July 2033, based on notional amount

Management anticipates the swaption will be settled by a payment of cash and not by the execution of an actual interest rate swap transaction, should the counterparty not elect to terminate.

The Alliance retains the right to terminate the swaption at any time prior to May 17, 2011 at its fair market value. A liability of $89,650 and $78,022, representing the estimated fair value of the swaption at June 30, 2010 and 2009, respectively, is included in estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. As a derivative financial instrument, this swaption is extremely sensitive to changes in long-term interest rates and other elements in the financial marketplace. As such, estimates of fair value are subject to significant changes in the near term.

Deferred financing and acquisition costs include $434 and $868 at June 30, 2010 and 2009, respectively, related to the costs of this transaction. The change in estimated fair value of derivatives in the accompanying Statement of Operations and Changes in Net Assets for 2010 and 2009 includes an unrealized loss of $11,628 and $9,195, respectively, related to this derivative.

Forward Sale Agreements: In June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. The forward sale agreements originally related to the Debt Service Reserve Fund and to the Debt Service Fund, respectively, (collectively, the "Funds"), as established under provisions

NOTE D--DERIVATIVE TRANSACTIONS - Continued

of the Master Trust Indenture related to the issuance of the Series 2000 Bonds. In consideration of the future earnings on the Funds, the counterparty paid the Master Trustee a total of $30,000 during 2005, to be held on behalf of the Alliance. In June 2006, one of these agreements was amended to also relate to the Series 2000C, 2000D, 2006A and 2006B Bonds, and to remove the Series 2000A Bonds from consideration under the agreement. As the original intent of these Funds was to secure debt service payments under the above referenced Bonds, the agreement requires these funds to be held under a guaranty agreement as further described below.

In connection with the issuance of the Series 2007 Bonds and the derecognition of a portion of the Series 2000A Bonds, all of the outstanding Series 2000B Bonds, and all of the outstanding 2006B Bonds (Note F), one of these agreements as it relates to the Series 2000A and 2000B Bonds was partially terminated. As such, during 2008 the Alliance reduced its liability with respect to the portion related to the Series 2000A and 2000B Bonds, and paid the counterparty $6,186 under the terms of the agreement. Management has represented that the other agreement will be amended in fiscal year 2011 to include the Series 2010A Bonds and to remove the Series 2000B and 2006B Bonds. As such, the Alliance has not reduced its liability for the portion related to the Series 2000B or 2006B Bonds under this agreement.

A liability of $19,864 and $20,728 representing the unamortized payments from the counterparty is included as part of deferred revenue in the accompanying Consolidated Balance Sheets as of June 30, 2010 and 2009, respectively. Amounts are being recognized as investment income over the life of the agreements.

Pursuant to these agreements, the counterparty required that the Alliance's obligations under the swaption and forward sale agreements be collateralized under a guarantee agreement in favor of the counterparty. Due to various requirements of the Master Trust Indenture, the Alliance transferred to MSF a total of $42,500 that was in turn deposited with the counterparty as collateral in a Guaranteed Investment Contract (GIC). Amounts received under the forward sale agreements were also deposited into the GIC. All GIC deposits earn interest compounded at 4.14% for the first year, and at 3.5% thereafter through July 1, 2011. The GIC deposits as of June 30, 2010 and 2009 totaled $89,486 and $86,364, respectively.

In the event the counterparty does not exercise the swaption, the Alliance will realize the swaption premium, forward sale amounts, and earnings on the GIC when the swaption expires on July 1, 2015. In the event the Alliance settles with the counterparty, the Alliance would in effect lose the earnings on these funds.

(Dollars in Thousands)

NOTE E--PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consist of the following at June 30:

	2010	2009
Land	$ 60,351	$ 51,484
Buildings and leasehold improvements	404,790	407,063
Property and improvements held for leasing	84,421	96,457
Equipment	479,523	424,738
Equipment held under capital lease	22,679	25,032
	1,051,764	1,004,774
Less: Allowances for depreciation and amortization	(569,913)	(505,600)
	481,851	499,174
Construction in progress (Note N)	213,747	91,395
	$ 695,598	$ 590,569

Accumulated depreciation and amortization on property and improvements held for leasing purposes is $21,543 and $21,829 at June 30, 2010 and 2009, respectively. Net interest capitalized was $11,117 and $3,744 for the years ended June 30, 2010 and 2009, respectively.

The Alliance is constructing two new hospital facilities, including Franklin Woods Community Hospital (FWCH) in Washington County, Tennessee and a replacement facility for JMH and has plans to construct a replacement facility at SCCH which will commence in 2011. The Alliance is also performing various renovations on existing hospital facilities. These projects may have a significant impact on the remaining useful life of the existing hospital facilities. Where commitments to construct new facilities have been finalized, management has adjusted the estimated useful lives of existing hospital facilities.

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS

Long-term debt and capital lease obligations consist of the following at June 30:

Description	Maturities	Rates	Outstanding Balance 2010	Outstanding Balance 2009
2010A Hospital Refunding Revenue Bonds, net of unamortized premium of $1,096 at June 30, 2010	$38,660 uninsured serially, through 2020	3.00% to 5.00%	$ 169,176	$ -
	$14,985 uninsured term bonds, due July 1, 2025	5.38%		
	$19,385 uninsured term bonds, due July 1, 2030	5.63%		
	$39,570 uninsured term bonds, due July 1, 2038	6.50%		
	$55,480 uninsured term bonds, due July 1, 2038	6.00%		
2010B Hospital Refunding Revenue Bonds, net of unamortized premium of $753 at June 30, 2010	$27,330 uninsured serially, through 2020	2.50% to 5.00%	36,688	-
	$4,355 uninsured term bonds, due July 1, 2023	5.00%		
	$4,250 uninsured term bonds, due July 1, 2028	5.50%		

(Dollars in Thousands)

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

Description	*Maturities*	*Rates*	*Outstanding Balance*	
			2010	*2009*
2009A Hospital Revenue Bonds, net of unamortized discount of $126 and $129 at June 30, 2010 and 2009, respectively	$725 uninsured term bonds, due July 1, 2019 $1,730 uninsured term bonds, due July 1, 2029 $3,105 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	5,434	5,431
2009B Hospital Revenue Bonds	$5,535 uninsured term bonds, due July 1, 2038	8.00%	5,535	5,535
2009C Hospital Revenue Bonds, net of unamortized discount of $2,508 and $2,595 at June 30, 2010 and 2009, respectively	$21,100 uninsured term bonds, due July 1, 2019 $20,000 uninsured term bonds, due July 1, 2029 $74,855 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	113,447	113,360
2008A Hospital Revenue Bonds	$13,245 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	13,245	72,770
2008B Hospital Revenue Bonds	$54,050 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	54,050	54,230
2007A Hospital Revenue Bonds	$4,305 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	4,305	100,220
2007B Taxable Hospital Revenue Bonds	$314,190 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 2.42% at June 30, 2010	314,190	320,170
2007C Hospital Revenue Bonds	$1,900 uninsured term bonds, due July 1, 2032, subject to early redemption or tender	Variable, 0.91% at June 30, 2010	1,900	36,575
2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of $153 and $159 at June 30, 2010 and 2009, respectively	$7,265 uninsured serially, through 2019 $7,375 uninsured term bonds, due July 1, 2026 $20,505 uninsured term bonds, due July 1, 2031 $135,175 uninsured term bonds, due July 1, 2036	4.50% to 5.00% 5.25% 5.50% 5.50%	170,473	171,149
2001A Hospital First Mortgage Revenue Bonds	$23,900 term bonds, due July 1, 2026, subject to early redemption or tender	6.85%	23,900	24,600
2001 Hospital Refunding and Improvement Revenue Bonds (NCH), net of unamortized discount of $43 and $38 at June 30, 2010 and 2009, respectively	$675 insured term bonds, due December 1, 2010 $1,465 insured term bonds, due December 1, 2012 $1,635 insured term bonds, due December 1, 2014 $8,815 insured term bonds, due December 1, 2022	5.13% 5.75% 6.00% 6.00%	12,547	13,183
2000A Hospital First Mortgage Revenue Refunding Bonds	$28,417 insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030	6.63%	28,417	26,601
2000C Hospital First Mortgage Revenue Taxable Bonds	$35,335 insured term bonds, due July 1, 2026	8.50%	35,335	36,270
2000D First Mortgage Taxable Bonds	$15,225 insured term bonds, due July 1, 2026	8.50%	15,225	15,630
1998 Hospital Refunding and Improvement Revenue Bonds (JMH)	$1,125 uninsured serially, through 2011 $6,495 uninsured term bonds, due July 1, 2016 $7,620 uninsured term bonds, due July 1, 2028	5.00% 5.25% 5.38%	15,240	16,310
Capitalized lease obligations secured by buildings and equipment	Maturing through 2027	3.18% to 13.01%	16,715	17,211
Note payable secured by assets of Kingsport Ambulatory Surgery Center	Monthly principal and interest payments maturing through June 2010	5.50%	-	334
Note payable secured by property	Monthly principal and interest payments of $7 beginning March 2007 maturing February 2012. Note was paid-off in 2010	LIBOR + 1.25%	-	204
$7,500 promissory note secured by assets of Mediserve Medical Equipment of Kingsport, Inc.	Monthly principal and interest payments of $56 beginning February 2007 maturing December 2011; remaining principal of $6,473 due January 2012	LIBOR + 1.10%	6,064	6,647
Capitalized lease obligations secured by equipment	Various monthly payments of monthly principal and interest	Various	1,325	1,526
$7,482 promissory note secured by property and unsecured letter of credit	Monthly interest-only payments through maturity on December 31, 2010; paid off in 2010	$32 interest per month	-	7,450
Master installment payment agreement	$2,194 due August 1, 2010	Unspecified	2,194	3,140
$1,409 unsecured promissory note	Monthly principal and interest payments of $23 beginning July 2008 through September 2013; remaining principal and accrued interest due October 2014	LIBOR + 1.25%	920	1,202

(Dollars in Thousands)

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

Description	*Maturities*	*Rates*	*Outstanding Balance*	
			2010	*2009*
$1,800 note payable secured by property	Monthly interest-only payments through maturity in July 2009	3.74%	-	1,800
$10,221 note payable secured by property	Various annual principal and interest payments through April 2013	6.25%	7,836	10,221
$5,000 line of credit secured by investments	Payable on demand	LIBOR + 1.25%	-	5,039
$4,600 note payable secured by property	Monthly principal and interest payments of $50 beginning February 2009 maturing December 2013; remaining principal due January 2014. Note was paid-off in 2010	5.47%	-	4,377
$1,065 note payable secured by land	Monthly interest-only payments through April 2011; remaining principal and accrued interest due May 2011	5.50%	1,065	1,065
$6,332 promissory note secured by substantially all assets of the Alliance	Monthly principal payments of $35 plus accrued interest beginning July 2010 maturing June 2015; remaining principal due July 2015	LIBOR + 2.00%	6,332	-
$3,955 note payable secured by property	Monthly principal and interest payments of $27 beginning July 2010 maturing May 2015; remaining principal due June 2015	3.00%	3,955	-
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of $166 beginning July 2010 maturing June 2017	4.62%	11,900	-
Note payable under Master Financing Agreement, secured by Equipment	Monthly principal and interest payments of $56 beginning July 2010 maturing June 2017	3.75%	4,100	-
$4,926 convertible construction loan secured by property and assigned rents	Monthly interest-only payments through January 2011 followed by monthly principal and interest payments of $25 maturing December 2014; remaining principal and accrued interest due January 2015	Prime (stated minimum and maximum interest rates of 3.75% and 6.75%, respectively)	1,195	-
$1,885 line of credit secured by property	Monthly interest-only payments through March 2011 followed by monthly principal and interest payments of $9 maturing February 2015; remaining principal and accrued interest due March 2015	Prime - 0.50% (stated minimum and maximum interest rates of 3.50% and 6.25%, respectively)	265	-
			1,082,973	1,072,250
	Less current portion		(28,131)	(31,306)
			$ 1,054,842	$ 1,040,944

Series 2010 Bonds: In April 2010, the Alliance issued $168,080 (Series 2010A) and $35,935 Series 2010B fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance. The Alliance recognized a $3,029 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs related to the refinanced Series 2008A and the Series 2007A and 2007C debt issues discussed below.

Series 2009 Bonds

In March 2009, the Alliance issued $5,560 (Series 2009A), $5,535 (Series 2009B) and $115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMH, fund a debt service reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

In connection with its acquisition of a majority ownership in JMH, the Alliance assumed the then outstanding long-term debt of JMH, totaling $33,906, including the JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds as further described in the table above.

Series 2008 Bonds

In February 2008, the Alliance issued $72,770 (Series 2008A) and $54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. The payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit (the Letters of Credit). The Letters of Credit entitle the Master Trustee to draw amounts equal to the principal amounts of the Series 2008 Bonds outstanding and up to 35 days interest at a rate of 12%. The Letters of Credit expire on December 14, 2012 unless renewed or replaced. A portion ($59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

The variable rate of interest on the Series 2008 Bonds is determined weekly by the Remarketing Agent (Merrill Lynch), as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Series 2008 Bonds in the secondary market. In no event shall the variable rate on the Series 2008 Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee for the Series 2008A Bonds or the Commonwealth of Virginia for the Series 2008B Bonds. The Alliance has the option, upon written approval of the holder of the Letters of Credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

The Series 2008 Bonds are subject to optional and mandatory tender for purchase prior to maturity at the option of the holder, upon conversion to a fixed rate, upon conversion to a medium-term rate period, prior to the effective date of any substitute letter of credit, or upon the termination of the Letters of Credit. The optional and mandatory tender provisions generally call for the Master Trustee to purchase the outstanding Series 2008 Bonds at a purchase price equal to the principal amount thereof plus accrued interest upon a stated date as described in the tender notice delivered to the bond holders.

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

Series 2007 Bonds

In December 2007, the Alliance issued $104,355 (Series 2007A), $327,170 (Series 2007B taxable) and $36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. The payment of principal and interest on the Series 2007 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit (the Letters of Credit). The Letters of Credit entitle the Master Trustee to draw amounts equal to the principal amounts of the Series 2007 Bonds outstanding and up to 35 days interest at a rate of 12%. The Letters of Credit expire on December 14, 2012 unless renewed or replaced. A portion of the outstanding Series 2007A ($91,685) and Series 2007C ($32,840) Bonds were repaid from proceeds of the Series 2010 Bonds.

The variable rate of interest on the Series 2007 Bonds is determined weekly in the same manner as described above for the Series 2008 Bonds. In no event shall the variable rate on the Series 2007 Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the State of Tennessee for the Series 2007A and 2007B Bonds or the Commonwealth of Virginia for the 2007C Bonds. The Alliance has the option, upon written approval of the holder of the Letters of Credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate. Upon such conversion, the Series 2007 Bonds become subject to mandatory tender for purchase.

The Series 2007 Bonds are subject to optional and mandatory tender in the same manner as described above for the Series 2008 Bonds. In addition, the Series 2007B Bonds are subject to a special mandatory tender with respect to its conversion from taxable debt to tax-exempt debt.

Series 2006 Bonds

During 2006, the Alliance issued $173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and $66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

Series 2001 Bonds

During 2001, the Alliance issued $26,000 Hospital First Mortgage Revenue Bonds (Series 2001A) and $60,175 Hospital First Mortgage Revenue Bonds (Series 2001B). The Series 2001A Bonds were subject to optional tender by Bond holders. Effective July 1, 2007, the Alliance entered into an agreement whereby the beneficial owners of the Series 2001A Bonds have irrevocably waived their rights to tender the Bonds under the provisions of the respective Bond Indenture. The waiver will continue in effect through the maturity of the 2001A Bonds. The Series 2001B Bonds were refunded and redeemed in 2006.

Series 2000 Bonds

The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were intended to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date $14,680 of insured Capital Appreciation Bonds. Such bonds bear a 0% coupon rate and have a yield of 6.625% annually. The Alliance recognizes interest expense and increases the amount of outstanding debt each year based upon this yield. Total principal and interest due at maturity (2026 through 2030) is $93,675.

The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. Management, upon advice of legal counsel, believes the amounts deposited in such irrevocable trust accounts have contractually relieved the Alliance of any future obligations with respect to this debt, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized.

Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2010 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately $585,960.

The assets placed in the irrevocable trust accounts are also not recognized as assets of the Alliance. These assets consist primarily of various investments, as permitted by bond indentures and other

(Dollars in Thousands)

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

documents, including United States Treasury obligations, an investment contract with MBIA Insurance Corporation (MBIA) in the amount of $54,300, as well as the Series 2000C and 2000D Bonds which were purchased with the proceeds of the 2000A and 2000B Bonds specifically for the purpose of utilizing the Series 2000C and 2000D Bonds in the irrevocable trust. Therefore, certain of the assets held in the irrevocable trust accounts have future income streams contingent upon payments by the Alliance.

Essentially all of the Alliance's bonds are subject to redemption prior to maturity, including optional, mandatory sinking fund and extraordinary redemption, at various dates and prices as described in the respective Bond indentures and other documents.

Other Bonds, Notes Payable and Financing Arrangements

The Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding bonds. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued.

The NCH Series 2001 Hospital Refunding and Improvement Revenue Bonds are secured by revenues and a lien on certain real and personal property of NCH. The JMH Series 1998 Hospital Refunding and Improvement Revenue Bonds are secured by pledged gross receipts of JMH, as defined in the Master Trust indenture.

The scheduled maturities and mandatory sinking fund payments of the long-term debt and capital lease obligations (excluding interest), exclusive of net unamortized original issue discount and premium, at June 30, 2010 are as follows:

Year Ending June 30,		
2011	$	28,131
2012		35,002
2013		30,312
2014		28,035
2015		31,898
Thereafter		930,227
		1,083,605
Net discount		(632)
	$	1,082,973

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

The Alliance, NCH and JMH are each members of separate Obligated Groups. The bond indentures, master trust indentures, letter of credit agreements and loan agreements related to the various bond issues and notes payable contain covenants with which the respective Obligated Groups must comply. These requirements include maintenance of certain financial and liquidity ratios, deposits to trustee funds, permitted indebtedness, use of facilities and disposals of property. These covenants also require that failure to meet certain debt service coverage tests will require the deposit of all daily cash receipts of the Alliance into a trust fund. Management has represented the Alliance, NCH and JMH are in compliance with all such covenants at June 30, 2010.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2010 or 2009.

In September 2010, in order to reduce credit risk and expenses, the Alliance replaced the existing letters of credit related to the Series 2007B, Series 2008A and Series 2008B Bonds with letters of credit held by several different financial institutions. The term of the letter of credit facility is for three years. As a part of this restructuring, the existing Bonds in these series were repaid through a remarketing of sub-series of each respective bond issue created per the mandatory tender and letter of credit substitution provisions.

NOTE G--SELF-INSURANCE PROGRAMS

The Alliance is self-insured for professional and general liability claims and related expenses. The Alliance maintains a $25,000 umbrella liability policy that attaches over the self-insurance limits of $10,000 per claim and a $15,000 annual aggregate retention. The Alliance also provides professional liability coverage for certain affiliates and joint ventures.

The Alliance is self-insured for workers' compensation claims in the State of Tennessee and has established estimated liabilities for both reported and unreported claims. The Alliance maintains a stop-loss policy that attaches over the self-insurance limits of $1,000 per occurrence and $1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2010, the Alliance is involved in litigation relating to medical malpractice and workers' compensation and other claims arising in the ordinary course of business. There are also known incidents occurring through June 30, 2010 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance

(Dollars in Thousands)

NOTE G--SELF-INSURANCE PROGRAMS - Continued

management has estimated and accrued for the cost of these unreported claims based on historical data and actuarial projections. The estimated net present value of malpractice and workers' compensation claims, both reported and unreported, as of June 30, 2010 and 2009 was $12,601 and $12,887, respectively. The discount rate utilized was 5% at June 30, 2010 and 2009.

Additionally, the Alliance is self-insured for employee health claims and recognizes expense each year based upon actual claims paid and an estimate of claims incurred but not yet paid, including a catastrophic claims reserve based on historical claims in excess of $75.

NOTE H--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations and Changes in Net Assets is as follows for the years ended June 30:

	2010	*2009*
Inpatient service charges	$ 1,848,590	$ 1,630,110
Outpatient service charges	1,669,705	1,253,097
Gross patient service charges	3,518,295	2,883,207
Less:		
Estimated contractual adjustments and other discounts	2,417,082	1,929,061
Estimated uncollectible self-pay - Note B	111,565	86,760
Charity care	61,378	44,488
	2,590,025	2,060,309
Net patient service revenue	$ 928,270	$ 822,898

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare, Blue Cross and various other commercial payors. The Medicare program pays for inpatient services on a prospective basis. Payments are based upon diagnosis related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. The Alliance also receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid and other low income patients. Most Medicare outpatient services are reimbursed on a prospectively determined payment methodology. The

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

Medicare program also reimburses certain other services on the basis of reasonable cost, subject to various prescribed limitations and reductions.

Reimbursement under the State of Tennessee's Medicaid waiver program (TennCare) for inpatient and outpatient services is administered by various managed care organizations (MCOs) and is based on diagnosis related group assignments, a negotiated per diem or fee schedule basis. The Alliance also receives additional supplemental payments from the State of Tennessee. The amount recognized totaled $8,700 and $11,137 for the years ended June 30, 2010 and 2009, respectively. Such payments are not guaranteed in future periods.

The Virginia Medicaid program reimbursement for inpatient hospital services is based on a prospective payment system using both a per case and per diem methodology. Additional payments are made for the allowable costs of capital. Payments for outpatient services are based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

Amounts earned under the contractual agreements with the Medicare and Medicaid programs are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Activity with respect to audits and reviews of the governmental programs in the healthcare industry has increased and is expected to increase in the future. No additional specific reserves or allowances have been established with regard to these increased audits and reviews as management is not able to estimate such amounts. Management believes that any adjustments from these increased audits and reviews will not have a material adverse impact on the consolidated financial statements. However, due to uncertainties in the estimation, it is at least reasonably possible that management's estimate will change in 2011, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates decreased net patient service revenue by $3,540 in 2009. The impact of final settlements of cost reports or changes in estimates were not significant in 2010.

Participation in the Medicare program subjects the Alliance to significant rules and regulations; failure to adhere to such could result in fines, penalties or expulsion from the program. Management believes that adequate provision has been made for any adjustments, fines or penalties which may result from final settlements or violations of other rules or regulations. Management has represented that the Alliance is in substantial compliance with these rules and regulations as of June 30, 2010.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis

NOTE I--THIRD-PARTY REIMBURSEMENT - Continued

for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

NOTE J--EMPLOYEE BENEFIT PLANS

The Alliance sponsors a retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists mainly of employer-funded contributions. During 2010 and 2009, the Alliance made contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. In addition, the Alliance sponsors a 403(b) plan which is funded solely by employees' contributions. The Alliance does not make any discretionary or matching contributions into the 403(b) plan. Employees of certain other subsidiaries are covered by other plans, although such plans are not significant. The total expense related to defined contribution plans for the years ended June 30, 2010 and 2009 was $13,311 and $10,590, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was $1,942 and $1,972, and the accrued unfunded post-retirement liability was $3,843 and $4,821 at June 30, 2010 and 2009, respectively.

The Alliance sponsors a secured executive benefit program (SEBP) for certain key executives. Contributions to the plan by the Alliance are based on an annual amount of funding necessary to produce a target benefit for the participants at their retirement date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed $1,303 and $1,716 to the plan during 2010 and 2009, respectively. Other assets at June 30, 2010 and 2009 include $7,077 and $5,827, respectively, related to the Alliance's portion of the benefits which are recoverable upon the death of the participant. In addition, the Alliance sponsors a Section 457(f) plan for certain key executives. The benefits for substantially all employees previously participating in the SEBP plan have been transferred into the 457(f) plan.

NOTE K--CONCENTRATIONS OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 54% and 59% of total net patient service revenue for 2010 and 2009, respectively.

The mix of receivables from patients and third-party payors based on charges at established rates is as follows as of June 30:

(Dollars in Thousands)

NOTE K--CONCENTRATIONS OF RISK - Continued

	2010	*2009*
Medicare	42%	40%
Tenncare/Medicaid	15%	17%
Commercial	25%	31%
Other third-party payors	10%	5%
Patients	8%	7%
	100%	100%

Approximately 98% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2010 and 2009. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements. These agreements expire in January 2011.

The Alliance routinely invests in investment vehicles as listed in Note C. The Alliance's investment portfolio is managed by outside investment management companies. Investments in corporate and foreign bonds and notes, municipal obligations, money market funds, equities and other vehicles that are held by safekeeping agents are not insured or guaranteed by the U.S. government.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2010 and 2009, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of $32,447 and $35,448, respectively, related to operating losses which expire through 2025. BRMM had state net operating loss carryforwards of $59,860 and $58,771, respectively, which expire through 2025. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and Tennessee Code Annotated.

At June 30, 2010 and 2009, SWCH had federal and state net operating loss carryforwards of $4,376 and $3,923, respectively, which expire through 2029. CHC files separate federal and state tax returns. CHC had a net deferred tax liability of $58 at June 30, 2010 and a net deferred tax asset of $55 at June 30, 2009; the differences are due primarily to temporary timing differences related to depreciation and net operating loss carryforwards. The net operating loss carryforwards may be off-set against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

NOTE L--INCOME TAXES - Continued

Net deferred tax assets related to these carryforwards and other deferred tax assets have been substantially offset through valuation allowances equal to these amounts. Income taxes paid relate primarily to state taxes for certain subsidiaries and federal alternative minimum tax.

NOTE M--RELATED PARTY TRANSACTIONS

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2010 represents costs incurred related to various hospital and medical office building facility renovations and additions. The Alliance has outstanding contracts and other commitments related to the completion of these projects, and the cost to complete these projects is estimated to be approximately $223,847 at June 30, 2010. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Physician Contracts: BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Upon completion of the respective guarantee period, amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician note may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of $1,818 and $2,770 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2010 and 2009, respectively.

Employee Scholarships: The Alliance offers scholarships to certain individuals which require that the recipients return to the Alliance to work for a specified period of time after they complete their degree. Amounts due are then forgiven over a specific period of time as provided in the individual contracts. If the recipient does not return and work the required period of time, the funds disbursed on their behalf become due immediately and interest is charged until the funds are repaid. Other receivables June 30, 2010 and 2009 includes $5,571 and $3,880, respectively, related to students in

(Dollars in Thousands)

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program.

Promises to Give: The Alliance has recorded certain unconditional promises to give to unrelated organizations. At June 30, 2010, $1,768 is due within one year, and an additional $644 is due within five years and is included in other long-term liabilities.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2010 and 2009 was $10,216 and $9,412, respectively. Future minimum lease payments for each of the next five years and in the aggregate for the Alliance's noncancellable operating leases with remaining lease terms in excess of one year are as follows:

Year Ending June 30,		
2011	$	1,686
2012		1,560
2013		1,345
2014		1,000
2015		835
Thereafter		3,808
	$	10,234

Estimated future minimum payments under various noncancellable maintenance contracts with remaining terms in excess of one year at June 30, 2010 total in the aggregate $3,720 through 2015.

Asset Retirement Obligation: The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

Other: During 2007, the Alliance received a Certificate of Need (CON) application to build a new 80-bed hospital in Washington County, Tennessee. When this new facility (FWCH) is opened in 2011, acute care services are planned to be discontinued or reduced at both NSH and JCSH. Management anticipates that the NSH and JCSH facilities will continue to be fully utilized by the

(Dollars in Thousands)

NOTE N--OTHER COMMITMENTS AND CONTINGENCIES - Continued

Alliance in its operations and, therefore, no change to their estimated useful lives is anticipated. However, it is reasonably possible management's estimates related to the continuing use of these facilities could change in the near term. The carrying value of buildings and improvements related to these facilities is $12,493 at June 30, 2010.

During 2007, the Alliance filed a Certificate of Public Need (COPN) application to build a new 57-bed hospital in Smyth County, Virginia. The COPN has been approved by the applicable Commonwealth of Virginia agencies. Construction is expected to begin in 2011 and total costs are expected to be $68,216.

The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future.

NOTE O--RENTAL INCOME UNDER OPERATING LEASES

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2010:

Year Ending June 30,		
2011	$	1,648
2012		1,545
2013		995
2014		730
2015		615
Thereafter		858
Total minimum future rentals	$	6,391

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2010 and 2009, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Alliance could realize in a current market exchange. The carrying value of substantially all financial instruments approximates fair value due to the nature or term of the instruments, except as described below.

NOTE P--FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

Other Long-Term Liabilities: Estimates of reported and unreported professional liability claims, pension and post-retirement liabilities are discounted to approximate their estimated fair value. It is not practical to estimate the fair market value of other long-term liabilities due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

Long-Term Debt and Capital Leases: The fair value of long-term debt is estimated based upon quotes obtained from brokers for bonds and discounted future cash flows using current market rates for other debt. For long-term debt with variable interest rates, the carrying value approximates fair value.

The Alliance's significant capital leases and vendor contracts were negotiated with various entities and are considered unique. It is not practicable to estimate the fair value of these obligations under current conditions. Other capital lease obligations are not significant.

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

	2010		*2009*	
	Carrying Value	*Estimated Fair Value*	*Carrying Value*	*Estimated Fair Value*
FINANCIAL LIABILITIES:				
Long-term debt	$ 1,082,973	$ 1,105,778	$ 1,072,250	$ 988,263

NOTE Q--FAIR VALUE MEASUREMENT

FASB ASC 820 establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 – Inputs based on quoted market prices for identical assets or liabilities in active markets at the measurement date.

- Level 2 - Observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar assets and liabilities in markets that are not active; or other inputs that are observable or can be corroborated by observable market data.

(Dollars in Thousands)

NOTE Q--FAIR VALUE MEASUREMENT - Continued

- Level 3 - Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Alliance's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Alliance's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis as of June 30, 2010 and 2009:

	June 30, 2010	*Level 1*	*Level 2*	*Level 3*
Trading securities	$ 209,644	$ 164,510	$ 16,526	$ 28,608
Assets whose use is limited	177,180	177,180	-	-
Total assets	$ 386,824	$ 341,690	$ 16,526	$ 28,608
Fair value of derivative agreements	$ (134,300)	$ -	$ -	$ (134,300)

	June 30, 2009	*Level 1*	*Level 2*	*Level 3*
Trading securities	$ 235,065	$ 191,918	$ 13,116	$ 30,031
Assets whose use is limited	186,414	186,414	-	-
Total assets	$ 421,479	$ 378,332	$ 13,116	$ 30,031
Fair value of derivative agreements	$ (126,217)	$ -	$ -	$ (126,217)

The valuation of the Alliance's derivative agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses observable market-based inputs, including forward interest rate curves. The fair values of interest rate swap agreements are determined by netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments). The variable cash receipts (or payments) are based on the expectation of future interest rates based on observable market forward interest rate curves and the underlying notional amount. The Alliance also

(Dollars in Thousands)

NOTE Q--FAIR VALUE MEASUREMENT - Continued

incorporates credit valuation adjustments (CVAs) to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. The CVA on the Alliance's interest rate swap agreements at June 30, 2010 and 2009 resulted in a decrease in the fair value of the related liability of $10,085 and $7,914, respectively.

A certain portion of the inputs used to value its interest rate swap agreements, including the forward interest rate curves and market perceptions of the Alliance's credit risk used in the CVAs, are unobservable inputs available to a market participant. As a result, the Alliance has determined that the interest rate swap valuations are classified in Level 3 of the fair value hierarchy.

The following tables provide a summary of changes in the fair value of the Alliance's Level 3 financial assets and liabilities during the fiscal years ended June 30, 2010 and 2009:

	Trading Securities	*Derivatives, Net*
July 1, 2008	$ 32,187	$ (87,295)
Total unrealized/realized losses in the performance indicator, net	(9,298)	(42,128)
Purchases, issuance and settlements and other, net	1,015	3,206
Transfers in (out), net	6,127	-
June 30, 2009	30,031	(126,217)
Total unrealized/realized losses in the performance indicator, net	(1,546)	(8,607)
Purchases, issuance and settlements and other, net	1,446	524
Transfers in (out), net	(1,323)	-
June 30, 2010	$ 28,608	$ (134,300)
Net losses included in the performance indicator which are attributable to the change in unrealized gains or losses relating to assets still held at June 30, 2009	$ (9,298)	$ (43,172)
Net losses included in the performance indicator which are attributable to the change in unrealized gains or losses relating to assets still held at June 30, 2010	$ (1,920)	$ (27,116)

On July 1, 2009, the Alliance adopted the provisions of FASB ASC 820 related to non-financial assets and liabilities recognized or disclosed at fair value on a non-recurring basis. The Alliance does not have any non-financial liabilities recognized or disclosed at fair value on a non-recurring basis. Assets subject to this guidance primarily include certain goodwill, property and equipment

(Dollars in Thousands)

NOTE Q--FAIR VALUE MEASUREMENT - Continued

and investments in unconsolidated affiliates. There were no significant assets or liabilities that were re-measured at fair value on a non-recurring basis during the fiscal year ended June 30, 2010.

NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

Direct expenses by functional classification are as follows for the years ended June 30:

	2010	*2009*
Healthcare services	$ 795,725	$ 686,779
Administrative and general	124,338	135,994
Other	8,625	10,168
	$ 928,688	$ 832,941

Supplemental Schedules

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet
(Dollars in Thousands)

June 30, 2010

	*Blue Ridge Medical Management **	*Other Obligated Group Members*	*Eliminations*	*Total Obligated Group*	*Mountain States Properties*	*Other Entities*	*Eliminations*	*Total*
ASSETS								
CURRENT ASSETS								
Cash and cash equivalents	$ 1,043	$ 204,966	$ -	$ 206,009	$ 7,566	$ 20,951	$ -	$ 234,526
Current portion of investments	-	9,588	-	9,588	14,120	4,759	-	28,467
Patient accounts receivable, less estimated allowances for contractual adjustments and uncollectible accounts	4,457	84,416	-	88,873	-	36,707	-	125,580
Other receivables, net	352	10,277	-	10,629	788	6,509	-	17,926
Inventories and prepaid expenses	192	18,977	-	19,169	183	9,811	-	29,163
TOTAL CURRENT ASSETS	6,044	328,224	-	334,268	22,657	78,737	-	435,662
INVESTMENTS, less amounts required to meet current obligations	17,166	266,104	-	283,270	18,765	284,721	-	586,756
PROPERTY, PLANT AND EQUIPMENT, net	9,152	463,652	-	472,804	66,295	156,499	-	695,598
EQUITY IN AFFILIATES	138,930	391,644	(160,670)	369,904	-	-	(369,904)	-
OTHER ASSETS								
Goodwill, net of accumulated amortization	6,246	143,276	-	149,522	-	1,830	-	151,352
Net deferred financing, acquisition costs and other charges, less current portion	176	28,458	-	28,634	1,540	645	-	30,819
Other assets	10,695	8,087	-	18,782	3,608	6,923	-	29,313
TOTAL OTHER ASSETS	17,117	179,821	-	196,938	5,148	9,398	-	211,484
	$ 188,409	$ 1,629,445	$ (160,670)	$ 1,657,184	$ 112,865	$ 529,355	$ (369,904)	$ 1,929,500

* Management Services Organization only

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet - Continued
(Dollars in Thousands)

June 30, 2010

	*Blue Ridge Medical Management **	*Other Obligated Group Members*	*Eliminations*	*Total Obligated Group*	*Mountain States Properties*	*Other Entities*	*Eliminations*	*Total*
LIABILITIES AND NET ASSETS								
CURRENT LIABILITIES								
Accrued interest payable	$ -	$ 15,550	$ -	$ 15,550	$ 4	$ 485	$ -	$ 16,039
Current portion of long-term debt and capital lease obligations	550	23,743	-	24,293	50	3,788	-	28,131
Current portion of estimated fair value of derivatives	-	-	-	-	10,740	-	-	10,740
Accounts payable and accrued expenses	2,159	76,098	-	78,257	1,317	19,653	-	99,227
Accrued salaries, compensated absences and amounts withheld	2,695	31,604	-	34,299	-	12,981	-	47,280
Payables to (receivables from) affiliates, net	9,392	(10,146)	-	(754)	(33,334)	34,088	-	-
Estimated amounts due to third-party payors, net	-	7,983	-	7,983	-	2,172	-	10,155
TOTAL CURRENT LIABILITIES	14,796	144,832	-	159,628	(21,223)	73,167	-	211,572
OTHER LIABILITIES								
Long-term debt and capital lease obligations, less current portion	5,515	1,006,038	-	1,011,553	1,144	42,145	-	1,054,842
Estimated fair value of derivatives, less current portion	-	123,308	-	123,308	252	-	-	123,560
Deferred revenue	-	20,092	-	20,092	-	353	-	20,445
Estimated professional liability self-insurance	2,229	5,075	-	7,304	-	2,237	-	9,541
Other long-term liabilities	5,199	1,598	-	6,797	-	5,831	-	12,628
TOTAL LIABILITIES	27,739	1,300,943	-	1,328,682	(19,827)	123,733	-	1,432,588
MINORITY INTERESTS	-	-	-	-	-	168,410	-	168,410
NET ASSETS								
Unrestricted net assets	160,670	317,434	(160,670)	317,434	132,692	226,356	(359,048)	317,434
Temporarily restricted net assets	-	10,941	-	10,941	-	10,729	(10,729)	10,941
Permanently restricted net assets	-	127	-	127	-	127	(127)	127
TOTAL NET ASSETS	160,670	328,502	(160,670)	328,502	132,692	237,212	(369,904)	328,502
	$ 188,409	$ 1,629,445	$ (160,670)	$ 1,657,184	$ 112,865	$ 529,355	$ (369,904)	$ 1,929,500

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations and Changes in Net Assets
(Dollars in Thousands)

Year Ended June 30, 2010

	*Blue Ridge Medical Management **	*Other Obligated Group Members*	*Eliminations*	*Total Obligated Group*	*Mountain States Properties*	*Other Entities*	*Eliminations*	*Total*
CHANGES IN UNRESTRICTED NET ASSETS:								
Revenue, gains and support:								
Net patient service revenue	$ 32,979	$ 657,122	$ (1,556)	$ 688,545	$ -	$ 239,921	$ (196)	$ 928,270
Other operating revenue	24,046	3,914	(18,087)	9,873	7,430	32,519	(33,813)	16,009
Equity in net gain of affiliates	6,702	4,959	(5,460)	6,201	-	15	(6,216)	-
TOTAL REVENUE, GAINS AND SUPPORT	63,727	665,995	(25,103)	704,619	7,430	272,455	(40,225)	944,279
Expenses:								
Salaries and wages	15,053	225,269	-	240,322	139	87,975	(2,773)	325,663
Physician salaries and wages	28,752	1,133	-	29,885	-	49,009	(24,405)	54,489
Contract labor	873	3,460	-	4,333	-	2,499	(286)	6,546
Employee benefits	5,152	43,758	(1,615)	47,295	39	22,587	(1,559)	68,362
Fees	2,206	76,192	(18,018)	60,380	830	21,867	(535)	82,542
Supplies	2,200	132,563	-	134,763	1	40,898	(193)	175,469
Utilities	510	10,078	-	10,588	1,010	4,595	-	16,193
Other	4,024	39,787	(11)	43,800	2,611	25,482	(4,253)	67,640
Depreciation	1,059	42,890	-	43,949	2,585	21,902	-	68,436
Amortization	266	12,711	-	12,977	-	146	-	13,123
Estimated provision for bad debts	1,522	3,822	-	5,344	-	2,617	-	7,961
Interest and taxes	(1,279)	41,601	-	40,322	1,409	4,787	(4,254)	42,264
TOTAL EXPENSES	60,338	633,264	(19,644)	673,958	8,624	284,364	(38,258)	928,688
OPERATING INCOME	3,389	32,731	(5,459)	30,661	(1,194)	(11,909)	(1,967)	15,591
Nonoperating gains (losses):								
Interest and dividend income	546	10,904	-	11,450	791	9,311	(4,254)	17,298
Net realized gains on the sale of securities	128	1,543	-	1,671	-	714	-	2,385
Net unrealized gains on securities	596	8,083	-	8,679	1,312	5,027	-	15,018
Derivative related income	-	2,622	-	2,622	1,772	-	-	4,394
Loss on early extinguishment of debt	-	(3,029)	-	(3,029)	-	-	-	(3,029)
Change in estimated fair value of derivatives	-	(10,865)	-	(10,865)	2,258	-	-	(8,607)
Other nonoperating gains (losses)	800	2,502	-	3,302	533	(3,323)	-	512
Net assets released from restrictions used for operations	-	-	-	-	-	1,113	-	1,113
NET NONOPERATING GAINS	2,070	11,760	-	13,830	6,666	12,842	(4,254)	29,084
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES, BEFORE MINORITY INTERESTS	5,459	44,491	(5,459)	44,491	5,472	933	(6,221)	44,675

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations and Changes in Net Assets - Continued
(Dollars in Thousands)

Year Ended June 30, 2010

	*Blue Ridge Medical Management **	*Other Obligated Group Members*	*Eliminations*	*Total Obligated Group*	*Mountain States Properties*	*Other Entities*	*Eliminations*	*Total*
Minority interest in consolidated subsidiaries' net gain	-	-	-	-	-	(3,162)	-	(3,162)
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	5,459	44,491	(5,459)	44,491	5,472	(2,229)	(6,221)	41,513
Other changes in unrestricted net assets:								
Pension and other defined benefit plan adjustments	-	-	-	-	-	1,589	-	1,589
Net assets released from restrictions used for the purchase of property, plant and equipment	-	-	-	-	-	2,283	-	2,283
INCREASE IN UNRESTRICTED NET ASSETS	5,459	44,491	(5,459)	44,491	5,472	1,643	(6,221)	45,385
DECREASE IN TEMPORARILY RESTRICTED NET ASSETS	-	(393)	-	(393)	-	(844)	-	(1,237)
DECREASE IN PERMANENTLY RESTRICTED NET ASSETS	-	-	-	-	-	(50)	-	(50)
INCREASE IN TOTAL NET ASSETS	5,459	44,098	(5,459)	44,098	5,472	749	(6,221)	44,098
NET ASSETS, BEGINNING OF YEAR	155,211	284,404	(155,211)	284,404	127,220	236,463	(363,683)	284,404
NET ASSETS, END OF YEAR	$ 160,670	$ 328,502	$ (160,670)	$ 328,502	$ 132,692	$ 237,212	$ (369,904)	$ 328,502

*Management Services Organization only.

See note to supplemental schedules.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Schedules

Year Ended June 30, 2010

NOTE A--OBLIGATED GROUP MEMBERS

As described in Note F to the consolidated financial statements, the Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding bonds. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. In accordance with Article Six, Section 6.6 of the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Trust Company, NA as Master Trustee, those members pledged include Johnson City Medical Center Hospital, Indian Path Medical Center and Pavilion, North Side Hospital, Sycamore Shoals Hospital, Johnson City Specialty Hospital, Johnson County Community Hospital, Russell County Medical Center and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating schedules include the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance, Mountain States Properties, Inc. (MSP) and all other affiliates (Other Entities), are not pledged to secure the payment of the outstanding bonds as they are not part of the Obligated Group. These affiliates have been accounted for within the Obligated Group based upon the Alliance's original and subsequent investments, as adjusted for the Alliance's pro rata share of income or losses and any distributions, and are included as a part of equity in affiliates in the supplemental consolidating balance sheet.

APPENDIX C

UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS FOR FISCAL YEAR ENDED JUNE 30, 2011

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MOUNTAIN STATES
HEALTH ALLIANCE

FINANCIAL REPORT

June 2011

Mountain States Health Alliance

Key Operating Indicators

For the Period Ended June 30, 2011

MONTH OF JUNE						TWELVE MONTHS YEAR TO DATE				
Actual	Budget	Bud Var	Prior Yr	PY Var		Actual	Budget	Bud Var	Prior Yr	PY Var
					Revenue and Expense as % of Patient Revenue					
52.1%	51.3%	0.9%	50.9%	1.2%	Inpatient Revenue	52.3%	52.4%	-0.1%	52.5%	-0.2%
47.9%	48.7%	-0.9%	49.1%	-1.2%	Outpatient Revenue	47.7%	47.6%	0.1%	47.5%	0.2%
100.0%	100.0%		100.0%		Total Gross Patient Revenue	100.0%	100.0%		100.0%	
72.1%	73.9%	1.9%	70.9%	-1.1%	Total Deductions	74.7%	74.5%	-0.2%	73.7%	-1.0%
27.9%	26.1%	1.9%	29.1%	-1.1%	Net Patient Service Revenue	25.3%	25.5%	-0.2%	26.3%	-1.0%
0.7%	0.5%	0.1%	0.6%	0.0%	Other Operating Revenue	0.5%	0.5%	-0.1%	0.5%	0.0%
28.6%	26.7%	1.9%	29.7%	-1.1%	Total Operating Revenue	25.7%	26.0%	-0.2%	26.8%	-1.1%
23.7%	25.7%	2.0%	25.2%	1.4%	Total Operating Expense	25.1%	25.4%	0.3%	26.4%	1.3%
4.9%	1.0%	3.9%	4.6%	0.3%	Net Operating Income	0.6%	0.5%	0.1%	0.4%	0.2%
1.0%	0.2%	0.8%	1.0%	0.1%	Investment Income	0.6%	0.3%	0.4%	0.7%	-0.1%
-3.4%	-0.2%	-3.2%	-2.4%	-1.0%	Other Non-Operating Income	0.4%	0.0%	0.4%	0.0%	0.4%
2.4%	1.0%	1.4%	3.8%	-1.4%	Total Excess Revenue Over Expense	1.6%	0.8%	0.7%	0.8%	0.8%
					Revenue By Source					
44.8%	44.3%	0.5%	43.5%	1.3%	Medicare	43.7%	44.2%	-0.5%	43.4%	0.3%
4.9%	4.7%	0.2%	5.4%	-0.5%	Medicaid	5.4%	5.0%	0.4%	5.3%	0.1%
8.0%	9.3%	-1.4%	8.5%	-0.5%	TennCare	8.3%	9.2%	-0.9%	9.0%	-0.6%
14.6%	13.7%	1.0%	12.7%	2.0%	Blue Cross	14.3%	13.7%	0.6%	13.4%	0.9%
6.7%	7.8%	-1.2%	8.1%	-1.4%	United - River Valley	7.4%	7.7%	-0.2%	7.7%	-0.2%
9.0%	8.9%	0.2%	10.2%	-1.1%	Managed Care / Commercial	9.4%	9.0%	0.4%	10.3%	-0.9%
9.2%	8.5%	0.6%	8.8%	0.4%	Charity / Self Pay	8.4%	8.5%	-0.2%	8.2%	0.2%
2.8%	2.5%	0.2%	2.9%	-0.1%	Other Patient Revenue	3.0%	2.5%	0.4%	2.8%	0.2%
100.0%	100.0%		100.0%		Total Gross Patient Revenue	100.0%	100.0%		100.0%	
					Operating Statistics (excl Nursing Home)					
781	765	2.1%	772	1.2%	Average Daily Census	789	802	-1.6%	800	-1.3%
46.2%	45.2%	2.1%	44.6%	3.6%	Occupancy Percent	46.7%	47.4%	-1.6%	46.2%	1.0%
23,444	22,953	2.1%	23,161	1.2%	Patient Days	288,167	292,877	-1.6%	291,986	-1.3%
5,131	4,850	5.8%	4,889	4.9%	Admissions	61,035	60,217	1.4%	60,102	1.6%
1,793	1,488	20.5%	1,598	12.2%	Observation Admissions	20,894	18,038	15.8%	18,358	13.8%
4.57	4.73	3.5%	4.74	3.6%	Average Length of Stay	4.72	4.86	2.9%	4.86	2.8%
45,081	44,889	0.4%	45,570	-1.1%	Adjusted Patient Days	552,056	559,978	-1.4%	556,594	-0.8%
9,866	9,485	4.0%	9,619	2.6%	Adjusted Admissions	116,930	115,134	1.6%	114,569	2.1%
133,471	137,364	-2.8%	134,414	-0.7%	Outpatient Visits	1,590,952	1,650,732	-3.6%	1,604,036	-0.8%
$7,189	$6,978	3.0%	$6,491	10.8%	IP Revenue per Patient Day	$6,844	$6,872	-0.4%	$6,310	8.5%
$1,165	$1,114	4.6%	$1,082	7.7%	OP Revenue per Outpatient Visit	$1,135	$1,112	2.1%	$1,041	9.1%
$2,053	$1,854	10.7%	$1,922	6.8%	Operating Revenue per Adjusted Patient Day	$1,757	$1,779	-1.3%	$1,687	4.2%
$1,700	$1,787	4.9%	$1,627	-4.5%	Operating Expense per Adjusted Patient Day	$1,714	$1,744	1.7%	$1,660	-3.3%
$9,379	$8,773	6.9%	$9,103	3.0%	Operating Revenue per Adjusted Admission	$8,294	$8,654	-4.2%	$8,194	1.2%
$7,769	$8,459	8.2%	$7,708	-0.8%	Operating Expense per Adjusted Admission	$8,094	$8,483	4.6%	$8,066	-0.3%
7,554	7,345	-2.8%	7,334	-3.0%	Employed Full Time Equivalents	7,393	7,410	0.2%	7,222	-2.4%
68	28	-142.3%	107	36.1%	Contract Full Time Equivalents	80	30	-166.7%	83	3.9%
7,622	7,373	-3.4%	7,441	-2.4%	Total Full Time Equivalents	7,473	7,440	-0.5%	7,305	-2.3%
5.07	4.93	-2.9%	4.90	-3.5%	FTEs per Adjusted Occupied Bed (incl Cont Lbr)	4.94	4.85	-1.9%	4.79	-3.1%
0.77	0.78	0.6%	0.77	0.1%	FTEs per Adjusted Admission (incl Cont Lbr)	0.77	0.78	1.1%	0.77	-0.2%
$44,808	$45,723	2.0%	$46,844	4.3%	Salary Expense per FTE (excl Cont Lbr)	$45,104	$45,409	0.7%	$44,788	-0.7%
$283	$322	11.9%	$255	-10.9%	Supply Expense per Adjusted Patient Day	$305	$321	4.9%	$314	2.9%
1.42	1.39	2.1%	1.46	-2.4%	Medicare Case Mix Index	1.44	1.39	3.3%	1.45	-0.7%
1.26	1.24	1.4%	1.27	-0.9%	Overall Case Mix Index	1.27	1.24	2.5%	1.27	-0.1%
1.44	1.45	-0.3%	1.49	-2.9%	Acute Medicare Case Mix Index	1.46	1.44	1.3%	1.48	-1.0%
1.33	1.33	0.6%	1.36	-1.9%	Acute Overall Case Mix Index	1.35	1.32	2.4%	1.36	-0.4%
					Operating Statistics (Nursing Home)					
2,863	3,070	-6.7%	2,755	3.9%	Nursing Home Patient Days	36,216	37,353	-3.0%	33,254	8.9%
27	20	35.0%	10	170.0%	Nursing Home Admissions	259	246	5.3%	109	137.6%
82	91	10.3%	76	-8.1%	Nursing Home Full Time Equivalents	83	91	9.3%	78	-6.0%

Mountain States Health Alliance

Statement of Revenue and Expense

For the Period Ended June 30, 2011

MONTH OF JUNE						TWELVE MONTHS YEAR TO DATE				
Actual	Budget	Bud Var	Prior Yr	PY Var		Actual	Budget	Bud Var	Prior Yr	PY Var
					Patient Revenue					
169,472,692	161,121,386	5.2%	150,826,676	12.4%	Inpatient Revenue	1,983,339,667	2,024,448,109	-2.0%	1,848,589,674	7.3%
155,608,467	153,142,228	1.6%	145,449,767	7.0%	Outpatient Revenue	1,806,960,043	1,836,530,529	-1.6%	1,669,704,738	8.2%
325,081,159	314,263,615	3.4%	296,276,443	9.7%	Total Gross Patient Revenue	3,790,299,709	3,860,978,637	-1.8%	3,518,294,412	7.7%
					Deductions from Revenue					
215,554,023	215,547,506	0.0%	200,750,371	-7.4%	Contractual Adjustments	2,647,862,693	2,685,018,483	1.4%	2,417,082,491	-9.5%
7,773,093	5,562,583	-39.7%	6,417,602	-21.1%	Charity	72,431,617	62,968,971	-15.0%	61,377,910	-18.0%
10,724,899	11,068,902	3.1%	2,770,398	-287.1%	Contra Revenue - Self Pay	109,876,805	128,614,923	14.6%	111,564,516	1.5%
176,370	147,733	-19.4%	189,544	7.0%	Cost of Goods Sold	1,495,076	1,707,215	12.4%	1,687,733	11.4%
234,228,385	232,326,725	-0.8%	210,127,916	-11.5%	Total Deductions	2,831,666,192	2,878,309,593	1.6%	2,591,712,650	-9.3%
90,852,774	81,936,890	10.9%	86,148,527	5.5%	***Net Patient Service Revenue***	958,633,517	982,669,045	-2.4%	926,581,762	3.5%
2,124,395	1,830,541	16.1%	1,862,235	14.1%	Other Operating Revenue	17,366,079	20,459,578	-15.1%	17,732,528	-2.1%
92,977,169	83,767,431	11.0%	88,010,761	5.6%	***Total Operating Revenue***	975,999,596	1,003,128,623	-2.7%	944,314,290	3.4%
					Operating Expense					
28,029,298	27,832,877	-0.7%	28,410,205	1.3%	Salaries	336,039,676	339,257,503	0.9%	325,657,566	-3.2%
4,890,399	4,753,677	-2.9%	4,443,016	-10.1%	Physician Salaries	59,248,821	57,333,537	-3.3%	54,488,895	-8.7%
501,615	191,321	-162.2%	719,344	30.3%	Contract Labor	5,963,680	2,850,824	-109.2%	6,546,022	8.9%
6,492,574	7,248,777	10.4%	5,300,324	-22.5%	Employee Benefits	67,209,284	87,478,304	23.2%	68,361,501	1.7%
7,586,997	6,941,212	-9.3%	7,169,396	-5.8%	Fees	85,918,912	83,111,663	-3.4%	82,541,487	-4.1%
12,859,262	14,512,738	11.4%	11,676,758	-10.1%	Supplies	169,362,052	180,628,404	6.2%	175,469,374	3.5%
1,552,929	1,424,650	-9.0%	1,418,312	-9.5%	Utilities	17,300,334	17,258,274	-0.2%	16,192,488	-6.8%
1,835,571	6,129,536	70.1%	4,079,879	55.0%	Other Expense	68,894,786	73,944,247	6.8%	67,640,314	-1.9%
9,606,960	5,788,929	-66.0%	6,092,293	-57.7%	Depreciation	87,499,453	78,723,483	-11.1%	68,436,438	-27.9%
383,665	180,507	-112.5%	1,120,232	65.8%	Amortization	2,559,141	2,194,779	-16.6%	13,122,700	80.5%
562,914	554,970	15.3%	970,420	42.0%	Bad Debt	6,327,970	7,828,581	19.2%	7,960,501	20.5%
2,774,534	5,019,373	44.7%	3,129,953	11.4%	Interest & Taxes	45,233,433	51,618,474	12.4%	42,264,136	-7.0%
1	0	-2558.0%	0	100.0%	Consolidation Allocation	(1)	(0)	-2749.8%	0	4900.0%
77,076,719	80,688,567	4.5%	74,530,132	-3.4%	***Total Operating Expense***	951,557,540	982,228,072	3.1%	928,681,421	-2.5%
15,900,450	3,078,864	416.4%	13,480,629	18.0%	***Net Operating Income***	24,442,056	20,900,551	16.9%	15,632,869	56.4%
3,344,352	1,384,467	141.6%	2,806,888	19.1%	Net Investment Income	21,257,492	18,125,952	17.3%	21,698,030	-2.0%
28,126	(666,667)	104.2%	114,991	-75.5%	Realized Gain on Investments	1,956,856	(8,000,000)	124.5%	2,385,122	-18.0%
44,348	69,157	-35.9%	72,827	-39.1%	Gain / (Loss) from Affiliates	829,906	829,889	0.0%	802,540	3.4%
156,500	0	100.0%	657,619	-76.2%	Gain / (Loss) on Disposal	517,406	0	100.0%	569,707	-25.0%
0	0	0.0%	(3,028,733)	100.0%	Loss on Extinguishment of LTD / Derivatives	0	0	0.0%	(3,028,733)	100.0%
(97,483)	(133,676)	27.1%	(2,294,112)	95.8%	Minority Interest	(3,348,513)	(919,311)	-264.3%	(3,046,909)	-9.9%
(8,013)	(8,342)	3.9%	(96,026)	91.7%	Taxes - Non Operating	(97,510)	(100,101)	2.6%	(187,790)	48.1%
(6,118,763)	(250)	-	42,616	-	Incentive Pay	(6,168,474)	(4,395)	-	(5,127)	-
(353,381)	(477,872)	24.0%	960,820	-137.8%	Other Non Operating Income / (Expense)	(985,838)	1,026,574	-196.0%	1,688,371	-158.4%
12,866,135	3,245,682	297.0%	12,717,520	1.3%	***Total Revenue Over Expense Before CFV of Derivatives***	38,403,281	31,859,159	20.5%	36,628,078	4.8%
(4,643,746)	0	100.0%	(3,518,998)	-32.0%	Change in Fair Value of Interest Rate Swaps	23,556,934	0	100.0%	3,021,250	679.7%
(408,776)	0	100.0%	1,996,319	-120.5%	Change in Fair Value of Call Option	(2,393,596)	0	100.0%	(11,628,330)	79.4%
7,833,613	3,245,682	141.4%	11,194,841	-30.0%	***Total Excess Revenue Over Expense***	59,566,619	31,859,159	87.0%	28,020,998	112.6%
(1,895,906)	666,667	-384.4%	(367,300)	-416.2%	Net Unrealized Gain / (Loss) on Investments	22,168,046	8,000,000	177.1%	15,018,465	47.6%
5,937,707	3,912,349	51.8%	10,827,541	-45.2%	***Total Increase in Unrestricted Net Assets***	81,734,665	39,859,160	105.1%	43,039,463	89.9%
25,659,307	14,242,833	80.2%	26,184,757	-2.0%	***EBITDA***	173,792,818	164,495,996	5.7%	153,667,875	6.2%

Mountain States Health Alliance

Comparative Balance Sheet

	June 30 2011	May 31 2011	Month Activity	June 30 2010	YTD Activity
ASSETS					
CURRENT ASSETS					
Cash and Cash Equivalents	112,932,971	127,654,537	(14,721,566)	240,872,146	(127,939,175)
Current Portion AWUIL	23,454,508	22,839,602	614,906	25,092,125	(1,637,618)
Accounts Receivable (Net)	135,023,319	137,803,753	(2,780,434)	125,579,502	9,443,817
Other Receivables	19,604,661	18,264,131	1,340,530	17,926,485	1,678,176
Due From Affiliates	28,533	(0)	28,533	(0)	28,533
Due From Third Party Payors	10,878,498	(0)	10,878,498	0	10,878,497
Inventories	23,092,574	22,048,796	1,043,778	21,593,059	1,499,515
Prepaid Expense	5,843,619	5,703,981	139,638	7,569,767	(1,726,148)
	330,858,681	334,314,799	(3,456,118)	438,633,084	(107,774,403)
ASSETS WHOSE USE IS LIMITED	194,326,848	203,695,968	(9,369,120)	274,073,320	(79,746,472)
OTHER INVESTMENTS	479,986,878	432,485,841	47,501,037	310,736,035	169,250,842
PROPERTY, PLANT AND EQUIPMENT					
Land, Buildings and Equipment	1,378,817,815	1,403,326,557	(24,508,742)	1,265,510,481	113,307,334
Less Allowances for Depreciation	586,470,519	643,365,634	(56,895,115)	569,912,724	16,557,795
	792,347,296	759,960,923	32,386,374	695,597,758	96,749,539
OTHER ASSETS					
Pledges Receivable	5,098,134	5,919,390	(821,256)	4,617,267	480,867
Long Term Compensation Investment	16,800,250	15,892,308	907,941	13,143,765	3,656,485
Investments in Unconsolidated Subsidiaries	2,366,851	2,508,752	(141,900)	2,417,968	(51,117)
Land / Equipment Held for Resale	57,635	57,635	0	57,635	0
Assets Held for Expansion	4,172,572	4,172,572	0	9,076,673	(4,904,101)
Investments in Subsidiaries	(0)	(0)	0	(0)	0
Goodwill	151,630,733	151,626,899	3,834	151,351,899	278,834
Deferred Charges and Other	29,192,400	29,412,702	(220,302)	29,796,050	(603,650)
	209,318,575	209,590,257	(271,683)	210,461,256	(1,142,682)
TOTAL ASSETS	2,006,838,277	1,940,047,788	66,790,489	1,929,501,454	77,336,824
LIABILITIES AND FUND BALANCE					
CURRENT LIABILITIES					
Accounts Payable and Accrued Expense	95,243,819	62,677,385	32,566,434	99,213,661	(3,969,842)
Accrued Salaries, Benefits, and PTO	57,788,998	49,221,614	8,567,384	47,280,030	10,508,968
Accrued Interest	20,079,964	16,969,509	3,110,455	16,038,509	4,041,455
Due to Affiliates	0	17,514	(17,514)	15,699	(15,699)
Due to Third Party Payors	25,914,943	23,269,210	2,645,733	10,154,973	15,759,970
Current Portion of Long Term Debt	28,050,459	29,906,835	(1,856,376)	28,131,238	(80,779)
	227,078,183	182,062,068	45,016,115	200,834,110	26,244,073
OTHER NON CURRENT LIABILITIES					
Long Term Compensation Payable	8,796,085	8,788,144	7,941	6,068,300	2,727,785
Long Term Debt	1,040,922,529	1,027,895,405	13,027,123	1,054,840,985	(13,918,457)
Estimated Fair Value of Interest Rate Swaps	20,573,187	15,972,101	4,601,086	44,649,145	(24,075,958)
Call Option Liability	92,044,033	91,635,257	408,776	89,650,437	2,393,596
Deferred Income	19,539,126	19,269,089	270,038	20,445,258	(906,132)
Professional Liability Self-Insurance and Other	16,189,889	18,719,725	(2,529,837)	16,100,901	88,988
	1,198,064,849	1,182,279,721	15,785,128	1,231,755,025	(33,690,178)
TOTAL LIABILITIES	1,425,143,032	1,364,341,789	60,801,243	1,432,589,136	(7,446,104)
MINORITY INTEREST	171,608,431	171,510,948	97,483	168,410,318	3,198,113
FUND BALANCE					
Restricted Fund Balance	10,739,628	11,210,361	(470,734)	10,935,552	(195,924)
Unrestricted Fund Balance	399,347,186	392,984,690	6,362,497	317,566,449	81,780,739
	410,086,815	404,195,052	5,891,764	328,502,000	81,584,815
TOTAL LIABILITIES AND FUND BALANCE	2,006,838,277	1,940,047,788	66,790,489	1,929,501,454	77,336,824

APPENDIX D

SUMMARY OF THE FINANCING DOCUMENTS

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SUMMARY OF THE FINANCING DOCUMENTS

Brief descriptions of the Master Indenture, each Bond Indenture and each Loan Agreement are included in this Appendix C to the Official Statement. Such descriptions do not purport to be comprehensive or definitive. All references herein to the Master Indenture, the Bond Indenture and the Loan Agreement are qualified in their entirety by reference to each such document, copies of which are available for review at the offices of the Mountain States Health Alliance, Legal Department, 400 North State of Franklin Road, Johnson City, Tennessee. All references to the Bonds of any Series are qualified in their entirety by reference to the definitive forms thereof and the information with respect thereto included in the Master Indenture or the Bond Indenture.

DEFINITIONS OF CERTAIN TERMS

The following are definitions of certain terms used in the Master Indenture, the Bond Indenture, the Loan Agreement and this Official Statement.

"Act of Bankruptcy" means any of the following events:

(a) The Alliance or the Issuer shall (1) apply for or consent to the appointment of, or the taking of possession by, a receiver, custodian, trustee, liquidator or the like of the Alliance or the Issuer or a substantial part of the property of either of them, (2) commence a voluntary case under the Federal Bankruptcy Code (as now or hereafter in effect) or (3) file a petition seeking to take advantage of any other law relating to bankruptcy, insolvency, reorganization, winding-up or composition or adjustment of debts; or

(b) A proceeding or case shall be commenced, without the application or consent of the Alliance or the Issuer, as the case may be, in any court of competent jurisdiction, seeking (1) the liquidation, reorganization, dissolution, winding-up, or the composition or adjustment of debts, of the Alliance or the Issuer, (2) the appointment of a trustee, receiver, custodian, liquidator or the like of the Alliance or the Issuer or of all or any substantial part of the assets of either the Alliance or the Issuer, or (3) similar relief in respect of the Alliance or the Issuer under any law relating to bankruptcy, insolvency, reorganization, winding-up or composition or adjustment of debts, and such proceeding or case shall continue undismissed, or an order, judgment or decree approving or ordering any of the foregoing shall be entered and continue unstayed and in effect for a period of 30 days from the commencement of such proceeding or case.

"Additional Indebtedness" means any Indebtedness (including all Obligations, other than the Initial Obligation) incurred by any Obligated Issuer, subsequent to its becoming an Obligated Issuer.

"Adjustment Date" means the first day of each Weekly Rate Period and each Medium-Term Rate Period.

"Affiliate" of any specified person means any other person directly or indirectly controlling or controlled by or under direct or indirect common control with such specified person. For purposes of this definition, (i) "control" when used with respect to any specified person means the power to direct the management and policies of such person, directly or indirectly, whether through the power to appoint and remove its directors, the ownership of voting securities, by contract, membership or otherwise; and (ii) the terms "controlling" and "controlled" have meanings correlative to the foregoing.

"Authorized Denominations" means prior to the Conversion Date, $100,000 or any integral multiple of $5,000 in excess thereof, provided that, with the written consent of the Issuer, "Authorized Denominations" shall mean after the Conversion Date, $5,000 or any integral multiple thereof.

"Balloon Indebtedness" means: (a) Long-Term Indebtedness as to which, when issued, 25% or more of the debt service thereon is due in a single year, or (b) Long-Term Indebtedness as to which, when issued, 25% or more of the original principal amount thereof may, at the option of the holder or registered owner thereof, be redeemed or repurchased at one time, which portion of the principal is not required by the documents pursuant to which such

Indebtedness is issued to be amortized by redemption prior to such date, or (c) any Guaranty of Long-Term Indebtedness that is Balloon Indebtedness.

"Bank" means each bank identified on the cover page, in its capacity as issuer of the Original Letter of Credit, its successors in such capacity and their assigns, until the Termination Date of the Original Letter of Credit and the payment in full to the Bank of all amounts owed to it under the Reimbursement Agreement and other related documents; provided, however, that upon the effective date of a Substitute Letter of Credit, "Bank" means the issuer of such Substitute Letter of Credit, its successors in such capacity and their assigns until the Termination Date of such Substitute Letter of Credit and the payment in full to such Bank of all amounts owed to it under the Reimbursement Agreement, if any, relating to such Substitute Letter of Credit.

"Bond Indenture" means the Bond Trust Indenture dated as of October 1, 2011, between the Issuer and the Bond Trustee, as amended and supplemented.

"Bond Index" means the "Bond Buyer Revenue Bond Index" as published from time to time in The Bond Buyer, or, if such index shall no longer be published, a comparable index designated by the Bond Insurer during the period that any Related Bonds are outstanding that are insured by the Bond Insurer and thereafter by the Obligated Group Agent.

"Bond Trustee" means The Bank of New York Mellon Trust Company, N.A. or any successor trustee under the Bond Indenture.

"Bondholder", "Owner", "owner", "Holder" or "holder" or any similar term, when used with reference to any of the Bonds, means (i) in the event that the book-entry system of evidence and transfer of ownership of the Bonds is employed pursuant to the Bond Indenture, Cede & Co., as nominee for DTC, or its nominee, and (ii) in all other cases, the registered owner or owners of any Bond as shown on the registration books maintained by the Bond Trustee.

"Book Value," when used in connection with Property of any member of the Obligated Group, means the cost of such Property, net of accumulated depreciation, calculated in conformity with generally accepted accounting principles, and when used in connection with Property of the Obligated Group, means the aggregate of the values so determined with respect to such Property of all members of the Obligated Group determined in such a manner that no portion of such value of Property of any member of the Obligated Group is included more than once.

"Borrower Bond" means any Bond registered in the name of the Alliance; provided, however, that in no event shall a Pledged Bond be deemed to be a Borrower Bond.

"Business Day" means any day other than (a) a Saturday or Sunday, (b) a day on which banking institutions in Tennessee, or in any other city where the principal United States office of the Bank, the Bond Trustee, the Remarketing Agent or any Paying Agent is located are required or authorized by law (including executive order) to close or on which the principal United States office of the Bank, the Bond Trustee, the Remarketing Agent, or any Paying Agent is closed for a reason not related to financial condition, or (c) a day on which The New York Stock Exchange is closed, provided that during the Fixed Rate Period, all references to the Bank or Remarketing Agent shall be ignored for purposes of this definition.

"Cash to Debt Ratio" means the ratio of Unrestricted Liquid Funds to Long Term Indebtedness.

"Chattel Paper" shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

"Code" means the Internal Revenue Code of 1986, as amended, as it applies to the Bonds, including applicable regulations and revenue rulings thereunder. Reference herein to sections of the Code are to the sections thereof as they exist on the date of execution of the Bond Indenture, but include any successor provisions thereof.

"Collateral" means (i) all Receivables, (ii) all Inventory, (iii) all Equipment, (iv) all General Intangibles, (v) all Contracts and all Contract rights, (vi) all amounts from time to time held in any checking, savings, deposit or other account of any Obligated Issuer, (vii) all Government Approvals, provided, that any Government Approval which by its terms or by the operation of law would become void, voidable, terminable or revocable if mortgaged, pledged or signed under the Master Indenture or if a security interest therein were granted under the Master Indenture or expressly accepted and excluded from the security interest by the Master Indenture granted to the extent necessary so as to avoid such voidness, voidability, terminability or revocability, (viii) all Fixtures, including but not limited to those now or hereafter attached to, placed on or incorporated in the Land, (ix) all Revenues, (x) without limiting the generality of the foregoing, all other personal property, goods, Instruments, Chattel Paper, Documents, credits, claims, demands and assets of any Obligated Issuer, whether now existing or hereafter acquired from time to time, and (xi) any and all additions and accessions to any of the foregoing, all improvements thereto, all substitutions and replacements therefor and all products and Proceeds thereof.

"Commitment Indebtedness" means the obligation of any person to repay amounts disbursed pursuant to a Credit Facility to pay when due such person's obligations under Indebtedness incurred in accordance with the provisions of the Master Indenture.

"Completion Indebtedness" means any Long-Term Indebtedness (i) incurred by any person for the purpose of financing the completion of constructing or equipping Facilities with respect to which Long-Term Indebtedness was theretofore incurred in accordance with the provisions hereof, and (ii) with a principal amount not in excess of the amount required (a) to provide a completed and equipped Facility of substantially the type and scope contemplated at the time such prior Long-Term Indebtedness was incurred, (b) to provide for capitalized interest during the period of construction, (c) to capitalize a reserve with respect to such Completion Indebtedness and (d) to pay the costs and expenses of issuing such Completion Indebtedness.

"Construction Index" means the health care component of the implicit price deflator for the gross national product as most recently reported prior to the date in question by the United States Department of Commerce or its successor agency, or, if such index is no longer published, such other index which is certified to be comparable and appropriate by the Obligated Group Agent in an Officer's Certificate delivered to the Master Trustee.

"Contract Rights" means all rights under any Contract to make determinations, to exercise any election (including, but not limited to, election of remedies) or option or to give or receive any notice, consent, waiver or approval together with full power and authority with respect to any Contract to demand, receive, enforce, collect or receipt for any of the foregoing rights or any property the subject of any of the Contracts, to enforce or execute any checks, or other instruments or orders, to file any claims and to take any action which, in the reasonable opinion of a secured party, may be necessary or advisable in connection with any of the foregoing.

"Contracts" means all contracts to which any Obligated Issuer now is, or hereafter will be, bound, or a party, beneficiary or assignee, including, without limitation, all instruments, agreements and documents executed and delivered with respect to such contracts, and all revenues, rentals, Proceeds and other sums of money due and to become due from any of the foregoing, as the same may be modified, supplemented or amended from time to time in accordance with their terms.

"Consultant" means a person who or which is appointed by the Obligated Group Agent for the purpose of passing on questions relating to the financial affairs, management or operations of one or more members of the Obligated Group or the entire Obligated Group and, in the good faith opinion of the Obligated Group Agent, has a favorable reputation for skill and experience in performing similar services in respect of entities engaged in reasonably comparable endeavors. If any Consultant's report or opinion is required to be given with respect to matters partly within and partly without the expertise of such Consultant, such Consultant may rely upon the report or opinion of another Consultant, which other Consultant shall be reasonably satisfactory to the relying Consultant and the Obligated Group Agent.

"Conversion Date" means the Interest Payment Date on which the Bonds begin to bear interest at the Fixed Rate.

"Corporation" or "Alliance" means Mountain States Health Alliance, a Tennessee not-for-profit corporation, and its successors and assigns and any surviving, resulting or transferee corporation.

"Counsel" means an attorney, or firm thereof, admitted to practice law before the highest court of any state in the United States of America or the District of Columbia.

"Credit Facility" means any letter of credit, line of credit, insurance policy, guaranty or other agreement constituting a credit enhancement or liquidity facility which is issued by a bank, trust company, savings and loan association or other institutional lender, insurance company or surety company for the benefit of the holder of any Indebtedness in order to provide a source of funds for, the payment of all or any portion of an Obligated Issuer's payment obligations under such Indebtedness.

"Days' Cash-on-Hand Ratio," as of the end of any Fiscal Year, means the product obtained by multiplying 365 times (i) the Unrestricted Liquid Funds of the Obligated Group as of the last day of such Fiscal Year, divided by (ii) the total operating expenses of the Obligated Group for such Fiscal Year, excluding depreciation and amortization expense and bad debt expense, as shown on the financial statements of the Obligated Group for such Fiscal Year.

"Debt Service Requirement" of any person means, for any period of time, the amounts payable or the payments required to be made by such person in respect of principal and interest on outstanding Long-Term Indebtedness during such period (calculated in such a manner that no portion of Long-Term Indebtedness is included more than once), taking into account (for purposes of calculating any projected debt service requirements) (i) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in the Master Indenture (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (ii) that any payments to be made in respect of Balloon Indebtedness and Variable Rate Indebtedness shall be calculated in accordance with the provisions of the Master Indenture, (iii) that, with respect to Indebtedness refunded or refinanced during such period, only an amount of principal and interest equal to the principal and interest not payable from the proceeds of Indebtedness shall be taken into account during such period, (iv) any amounts payable from funds available under an Escrow Deposit (other than amounts so payable solely by reason of the obligor's failure to make payments from other sources), shall be excluded from the determination of the Debt Service Requirement, and (v) that with respect to any Indebtedness which is the subject of a Hedge Agreement, any Regular Scheduled Qualified Swap Payments under such Hedge Agreement (provided, however, that if the Regular Scheduled Qualified Swap Payments are variable rate payments, interest shall be calculated as if the indebtedness was Variable Rate Indebtedness) payable or receivable with respect to such Indebtedness shall be taken into account in determining the interest payable with respect to such Indebtedness.[*]

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[*] By their purchase of the Bonds, the initial holders thereof will consent to an amendment of this definition as described in "SECURITY AND SOURCES OF PAYMENT FOR THE BONDS – Amendment of the Master Indenture" in the front part of this Official Statement. The proposed amended definition is as follows:

"Debt Service Requirement" of any Person shall mean, for any period of time, the amounts payable or the payments required to be made by such Person in respect of principal and interest on Outstanding Long-Term Indebtedness during such period (calculated in such a manner that no portion of the Long-Term Indebtedness is included more than once), taking into account (for purposes of calculating any projected debt service requirements) (i) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in Section 4.3 (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (ii) that any payments to be made in respect of Balloon Indebtedness and Variable Rate Indebtedness shall be calculated in accordance with the provisions of Section 4.4, (iii) that, with respect to Indebtedness refunded or refinanced during such period, only an amount of principal and interest equal to the principal and interest not payable from the proceeds of Indebtedness shall be taken into account during such period, (iv) any amounts payable from funds available under an Escrow Deposit (other than amounts payable solely by reason of the obligor's failure to make payments from other sources), shall be excluded from the determination of the Debt Service Requirement, and (v) that with respect to any Indebtedness which is the subject of a Hedge Agreement, the rate payable under such Hedge Agreement, rather than the actual interest payable on such Indebtedness, shall be taken into account in determining the interest payable with respect to such Indebtedness.

"Default" means any event which with the giving of notice or lapse of time, or both, would constitute an Event of Default.

"Defeasance Investments" means non-redeemable direct obligations of the United States of America or obligations for which the full faith and credit of the United States of America are pledged for the timely payment of principal and interest, including evidences of a direct ownership interest in future interest or principal payments on such obligations, which obligations are held in a custody account by a custodian pursuant to the terms of a custody agreement.

"Discounted Indebtedness" means Indebtedness sold to the original purchaser thereof (other than any underwriter or other similar intermediary) at a discount from the par amount of such Indebtedness.

"Document" shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

"Eligible Moneys" means (a) proceeds of Bonds not sold to the Alliance or the Issuer or an affiliate of the Alliance or the Issuer, (b) moneys irrevocably drawn under the Letter of Credit, (c) moneys deposited with the Bond Trustee by the Alliance for the benefit of the Bondholders for 123 days during which no Act of Bankruptcy has occurred as evidenced by a certificate of the Alliance or Issuer, (d) moneys with respect to which the Alliance delivers to the Bond Trustee an Opinion of Counsel with nationally recognized expertise in bankruptcy acceptable to the Bond Trustee and Moody's that such payments will not constitute a voidable transfer or preference under and pursuant to Section 547 of the Federal Bankruptcy Code and (e) investment income on the foregoing types of money.

"Equipment" means any "equipment," as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now or hereafter owned or leased by any Obligated Issuer and, in any event, shall include, but shall not be limited to, all equipment used in connection with the facilities constructed from time to time on the Land, all machinery, tools, office equipment, furniture, furnishings, fixtures, vehicles, motor vehicles, and any manuals, instructions, blueprints, computer software and similar items which relate to the above, and any and all additions, substitutions and replacements of any of the foregoing, wherever located, together with all improvements thereon and all attachments, components, parts, equipment and accessories installed thereon or affixed thereto.

"Escrow Deposit" means a segregated escrow fund or other similar fund, account or deposit in trust of cash in an amount (or Defeasance Investments the principal of and interest on which will be in an amount), and under terms, sufficient to pay all or a portion of the principal of, and premium, if any, and interest on, the indebtedness secured by such escrow fund or other similar fund, account or deposit as the same shall become due or payable upon redemption.

"Event of Default" shall, with respect to the Bond Indenture and Loan Agreement, respectively, have the meanings described under this Appendix C in "SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE - Events of Default" and "THE LOAN AGREEMENT- Events of Default And Remedies on Default."

"Facilities" means all land, leasehold interests and buildings and all fixtures and equipment of a person.

"Fair Value Net Worth" of a person as of any date means:

(i) the fair value or fair saleable value (as the case may be, determined in accordance, with applicable federal and state laws affecting creditors rights and governing determinations of insolvency of debtors) of such person's assets (including such person's rights to contribution and subrogation under Sections 2.3(d) and (f) of the Master Indenture or in respect of any other guarantee) as of such date, minus

(ii) the amount of all liabilities of such person (determined in accordance with such laws) as of such date, excluding (x) such person's Cross Guarantee and (y) any liabilities subordinated in right of payment to such Cross Guarantee, minus

(iii) $1.00.

"Fiscal Year" means a period of twelve consecutive months ending on June 30 or on such other date as may be specified in an Officer's Certificate of the Obligated Group Agent executed and delivered to the Master Trustee.

"Fitch" means Fitch Ratings, Inc., its successors and assigns; and if such corporation shall be dissolved or liquidated or shall no longer perform the function of a municipal securities rating agency, "Fitch" shall be deemed to refer to any other recognized municipal securities rating agency designated by the Alliance.

"Fixed Rate Period" means the period from and including the Conversion Date to and including the date next preceding the payment in full of the Bonds.

"Fixtures" shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction and in any event shall include all goods now or hereafter attached to, placed on, or incorporated in the Land.

"General Intangibles" means "general intangibles" as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now or hereafter owned by any Obligated Group Issuer and shall include, but not be limited to, all trademarks, trademark applications, trademark registrations, trade names, fictitious business names, business names, company names, business identifiers, prints, labels, trade styles and service marks (whether or not registered), including logos and/or designs, copyrights, patents, patent applications, goodwill of any Obligated Issuer's business symbolized by any of the foregoing, trade secrets, license rights, license agreements, permits, franchises, and any rights to tax refunds to which any Obligated Issuer is now or hereafter may be entitled.

"Governing Body" means, when used with respect to any person, its board of directors, board of trustees, or other board, committee or group of individuals in which the powers of a board of directors or board of trustees is vested generally or for the specific matters under consideration.

"Government Issuer" means any federal, state or municipal corporation or political subdivision thereof or any instrumentality of any of the foregoing empowered to issue obligations on behalf thereof.

"Government Obligations" means (i) for purposes of the Master Indenture, direct obligations of, or obligations the principal of and interest on which are unconditionally guaranteed by, the United States of America, including evidences of a direct ownership interest in future interest or principal payments on obligations issued or guaranteed by the United States of America, which obligations are held in a custody account by a custodian pursuant to the terms of a the terms of a custody agreement, and (ii) for purposes of the Bond Indenture, means direct general obligations of, or obligations the prompt payment of the principal of and the interest on which are fully and unconditionally guaranteed by, the United States of America. In addition, investments having a maturity of seven days or less in a money market fund rated Aaa by Moody's, investments of which fund are exclusively in Government Obligations, shall be considered investments in Government Obligations for purposes of the Bond Indenture.

"Gross Receipts" means all Revenues, operating revenues and non-operating revenues, receipts, rentals and income of, or received by, any Obligated Issuer, under generally accepted accounting principles, and all rights to receive the same, whether in the form of accounts receivable, Receivables, accounts, Documents, Investment Property, Contract Rights, Chattel Paper, Instruments, General Intangibles or other rights and all Proceeds thereof, including insurance proceeds and condemnation awards payable or paid in respect of the Facilities, whether now existing or hereafter coming into existence and whether now owned or hereafter acquired, and the proceeds thereof including, without limitation, revenues derived from the ownership, operation or leasing of the Facilities; provided, however, that there shall be excluded from Gross Receipts (i) all gifts, grants, bequests, donations or contributions (collectively, "gifts"), which gifts may not be pledged or applied to the payment of principal or interest on the Obligations as a result of restrictions or designations imposed by the donor or maker of the gift in question at the time of the making thereof and income therefrom if such income may not be pledged or applied to the payment of principal or interest on the Obligations as a result of a restriction or designation described in this clause (i), and (ii) any proceeds of any additional indebtedness incurred or assumed by the Obligated Issuer pursuant to the terms of

the Master Indenture, to the extent required by the terms of the documentation evidencing such additional indebtedness.

"Guaranty" means any obligation of a Obligated Group member guaranteeing any obligation of any other person other than a Obligated Group member, whether or not issued under the Master Indenture as an Indenture Guaranty, which obligation would, if such other person were a member of the Obligated Group, constitute Indebtedness under the Master Indenture.

"Hedge Agreement" means (a) any contract known as or referred to or which performs the function of an interest rate swap agreement, currency swap agreement, forward payment conversion agreement or futures contract; (b) any contract providing for payments based on levels of, or changes or differences in, interest rates, currency exchange rates, or stock or other indices; (c) any contract to exchange cash flows or payments or series of payments; (d) any type of contract called, or designed to perform the function of, interest rate floors, collars, or caps, options, puts, or calls, to hedge or minimize any type of financial risk, including, without limitation, payment, currency, rate or other financial risk; and (e) any other type of contract or arrangement that the Obligated Group Agent determines is to be used, to manage or reduce the cost of an Indebtedness, to convert any element of any Indebtedness from one form to another, to maximize or increase investment return, to minimize investment return risk, or to protect against any type of financial risk or uncertainty.

"Historical Debt Service Coverage Ratio" means, for any period of time, the ratio determined by dividing Total Income Available For Debt Service for such period by the Debt Service Requirement of the Obligated Group for such period.

"Historical Maximum Annual Debt Service Coverage Ratio" means, for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Obligated Group.

"Historical Pro Forma Debt Service Coverage Ratio" means for any period of time, the ratio determined by dividing Total Income Available for Debt Service for such period by the Maximum Annual Debt Service of the Obligated Group for all Long Term Indebtedness then outstanding and the Long-Term Indebtedness then proposed to be issued.

"Holder" means, as the context requires, the registered owner of any Note, the beneficiary of any Indenture Guaranty in whose name an Indenture Guaranty is issued or the holder or beneficiary of any other type of Obligation. In the case of an Obligation issued to a trustee or other fiduciary acting on behalf of the holders of any bonds, notes or other similar obligations which are secured by such Obligation, including any registered securities depositary then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by book-entry registration) substantial amounts of obligations of types comprising the Obligations, the term Holder shall mean the trustee or other fiduciary or, if so provided in the Related Financing Documents, the holders of the Related Bonds in proportion to their respective interests therein, including any registered securities depositary then in the business of holding (for the benefit of beneficial owners whose interests may be evidenced by book-entry registration) substantial amounts of obligations of types comprising the Obligations. For purposes of determining the Holders of the two largest principal amounts of Uninsured Obligations, any Holder of Related Bonds relating to Uninsured Obligations shall be deemed to be the owner of a proportionate amount of the Uninsured Obligations, and any such Uninsured Obligations owned by affiliated entities shall be treated as owned by one Holder.

"Immediate Notice" means notice (a) by telecopier or telephone, or delivery by hand, (b) promptly followed by written notice by first class mail, postage prepaid, and (c) to such address or such telex, telecopier or telephone number as the person receiving such notice shall have previously furnished to the Bond Trustee in writing.

"Income Available For Debt Service" of a person means, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income before tax, as determined in accordance with generally accepted accounting principles, to which shall be added, in either case, (i) depreciation, (ii) amortization, (iii) interest expense on Long-Term Indebtedness, and, to the extent not already included, and (iv) to the extent not already included contributions and donations and from which shall be excluded any extraordinary items, any impairment losses, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or

other disposition of assets not made in the ordinary course of business, provided, however, that (a) no determination of Income Available for Debt Service will take into account any gains or losses resulting from the periodic valuation of investments or Hedge Agreements that do not involve the sale, transfer or other disposition of any such investment or Hedge Agreement or the termination of any Hedge Agreement and (b) a person may include in its net income such person's share of the net income of any person controlled by such person or in whom such person has a legal interest.

"Indebtedness" of a person means (i) all Notes and Guaranties, (ii) all liabilities (exclusive of reserves such as those established for deferred taxes or litigation) recorded on the audited financial statements of such person as of the end of the most recent Fiscal Year for which financial statements reported upon by an Accountant are available, and (iii) all other obligations for borrowed money; provided that Indebtedness shall not include (1) Subordinated Indebtedness, (2) Hedge Agreements, (3) any other Indebtedness of any member of the Obligated Group to any other member of the Obligated Group, (4) rentals payable under leases which are not properly capitalized under generally accepted accounting principles or (5) any Guaranty by any member of the Obligated Group of Indebtedness of any other member of the Obligated Group.

"Indenture Guaranty" means any Guaranty issued under the Master Indenture by an Obligated Issuer.

"Instrument" shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

"Interest Payment Date" means (a) during Weekly Rate Periods, the first Business Day of each calendar month and any Conversion Date, Proposed Conversion Date or the maturity of the Bonds, and (b) during any Medium-Term Rate Periods and any Fixed Rate Period, each Long-Term Interest Payment Date.

"Interest Rate Swap Obligations" means obligations of any person pursuant to any arrangement with any other person whereby, directly or indirectly, such person is entitled to receive from time-to-time periodic payments calculated by applying either a floating or a fixed rate of interest on a stated principal amount in exchange for periodic payments made by such other person calculated by applying a fixed or a floating rate of interest on the same amount.

"Inventory" means all of the inventory of any Obligated Issuer of every type or description, including all inventory as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction, now owned or hereafter acquired and wherever located, whether raw, in process or finished, all materials usable in processing the same and all documents of title covering any inventory, including but not limited to work in process, materials used or consumed in such Obligated Issuer's business, now owned or hereafter acquired or manufactured by such Obligated Issuer and held for sale in the ordinary course of its business; all present and future substitutions therefor, parts and accessories thereof and all additions thereto; and all proceeds thereof and products of such inventory in any form whatsoever.

"Investment Property" shall have the meaning assigned that term under the Uniform Commercial Code as in effect in any relevant jurisdiction.

"Investment Securities" means, to the extent permitted by applicable law:

(i) Certificates or interest-bearing notes or obligations of the United States, or those for which the full faith and credit of the United States are pledged for the payment of principal and interest.

(ii) Investments in any of the following obligations, provided such obligations are backed by the full faith and credit of the United States: (a) the Export-Import Bank of the United States, (b) the Federal Housing Administration, (c) the Government National Mortgage Association ("GNMA"), (d) the Rural Economic Community Development Administration (formerly known as the Farmers Home Administration), (e) the Federal Financing Bank, (f) the Department of Housing and Urban Development, (g) the General Services Administration, (h) the U.S. Maritime Administration or (i) the Small Business Administration.

(iii) Investments in direct obligations in any of the following agencies, which obligations are not fully guaranteed by the full faith and credit of the United States: (a) senior obligations by the Federal Home Loan Bank System, (b) senior debt obligations and participation certificates (excluding stripped mortgage securities which are purchased at prices exceeding their principal amounts) issued by the Federal Home Loan Mortgage Corporation ("FHLMC") or senior debt obligations and mortgage-backed securities (excluding stripped mortgage securities which are purchased at prices exceeding their principal amounts) of the Federal National Mortgage Association ("FNMA"), (c) obligations of the Resolution Funding Corporation ("REFCORP"), or (d) senior debt obligations of the Student Loan Marketing Association ("SLMA") (excluding securities that do not have a fixed par value or whose terms do not promise a fixed dollar amount at maturity or call date).

(iv) Investments in (a) U.S. dollar denominated deposit accounts, federal funds, bankers acceptances, and certificates of deposit of any bank whose short-term debt obligations are rated A-1+ by S&P and P-1 by Moody's and maturing no more than 360 calendar days after the date of purchase (holding company ratings are not considered as rating of the bank) or (b) certificates of deposit of any bank, which certificates are fully insured by the Federal Deposit Insurance Corporation ("FDIC").

(v) Investments in money market funds rated "AAAm" or "AAAm-G" by S&P.

(vi) Commercial paper which is rated at the time of purchase in the single highest classification, "P-1" by Moody's, Inc. and "A-1+" by S&P and which matures not more than 270 calendar days after the date of purchase.

(vii) Pre-refunded municipal obligations defined as follows: any bonds or other obligations rated "AAA" by S&P and "Aaa" by Moody's (based on an irrevocable escrow account or fund) of any state of the United States of America or any agency, instrumentality or local governmental unit of any such state which are not callable at the option of the obligor prior to maturity or as to which irrevocable instructions have been given by the obligor to call on the date specified in the notice.

(viii) Municipal obligations rated "Aaa/AAA" or general obligations of states with a rating of "A1/A+" or higher by both Moody's and S&P at the time of purchase.

(ix) Repurchase agreements with (a) any domestic bank, or domestic branch of a foreign bank, the long-term debt which is rated at least "A" by S&P and "A2" by Moody's; or (b) any broker-dealer with "retail customers" or a related affiliate thereof, which broker-dealer has, or the parent company (which guarantees the provider) of which has, long-term debt rated at least "A" by S&P and "A2" by Moody's, which broker-dealer falls under the jurisdiction of the Securities Investors Protection Corporation; or (c) any other entity rated at least "A" by S&P and "A2" by Moody's; provided that:

(a) the repurchase agreement is collateralized with the obligations described in paragraphs (i) or (ii) above, or with obligations described in paragraph (iii)(a) and (b) above.

(b) the trustee will value the collateral securities at least weekly and will liquidate the collateral securities if any deficiency in the required collateral percentage is not restored within two (2) business days.

(c) the market value of the collateral must be maintained at: 104% of the total principal of the repurchase agreement for obligations described in paragraphs (i) and (ii); 105% of the total principal of the repurchase agreement for obligations described in paragraph (iii)(a) and (b) above.

(d) the trustee or a third party acting solely as agent therefor or for the issuer (the "Holder of the Collateral") has possession of the collateral or the collateral has been transferred to the Holder of the Collateral in accordance with applicable state and federal laws (other than by means of entries on the transferor's books).

(e) the repurchase agreement shall state, and an opinion of counsel shall be rendered at the time such collateral is delivered, that the Holder of the Collateral has a perfected first priority security interest in the collateral, and substituted collateral and all proceeds thereof.

(f) the repurchase agreement shall provide that if during its term the provider's rating by either Moody's or S&P is withdrawn or suspended or falls below "A-" by S&P or "A3" by Moody's, as appropriate, the provider must, at the direction of the Issuer or the trustee, within 10 days of receipt of such direction, repurchase all collateral and terminate the agreement, with no penalty or premium to the issuer or trustee.

(x) Investment agreements with (a) a domestic or foreign bank or corporation (other than a life or property casualty insurance company), the long-term debt of which, or, in the case of a guaranteed corporation, the long-term debt is rated at least "AA" by S&P and "Aa2" by Moody's at the time of purchase; or (b) a monoline municipal bond insurance company or a subsidiary thereof whose claims paying ability is rated at least "AA" by S&P and "Aa2" by Moody's at the time of purchase; provided, that in all cases, by the terms of the investment agreement:

(a) interest payments are to be made to the Bond Trustee at least one business day prior to debt service payment dates on the Bonds and in such amounts as are necessary to pay debt service (or, if the investment agreement is for the construction fund, construction draws) on the Bonds;

(b) the invested funds are available for withdrawal, without penalty or premium, at any time upon not more than seven days' prior notice (which notice may be amended or withdrawn at any time prior to the specified withdrawal date); provided that the [Indenture] specifically requires the Issuer or the Bond Trustee to give notice in accordance with the terms of the investment agreement so as to receive funds thereunder with no penalty or premium paid;

(c) the investment agreement shall state that it is the unconditional and general obligation of, and is not subordinated to any other obligation of, the provider thereof;

(d) a fixed guaranteed rate of interest is to be paid on invested funds and all future deposits, if any, required to be made to restore the amount of such funds to the level specified under the Bond Indenture;

(e) the term of the investment agreement does not exceed seven years;

(f) the Issuer or the Bond Trustee receives the opinion of domestic counsel that such investment agreement is legal, valid, binding and enforceable upon the provider in accordance with its terms and of foreign counsel (if applicable);

(g) the Bond Indenture and investment agreement shall provide that if, during its term:

(1) the provider's rating by either S&P or Moody's falls below "AA " or "Aa3," respectively, the provider must, at the direction of the Issuer or the Bond Trustee, within 10 days of receipt of such direction, either (i) collateralize the investment agreement by delivering or transferring in accordance with applicable state and federal laws (other than by means of entries on the provider's books) to the Issuer, the Bond Trustee or a third party acting solely as agent therefor Permitted Collateral which are free and clear of any third-party liens or claims at the Collateral Levels set forth below; or (ii) repay the principal of and accrued but unpaid interest on the investment (the choice of (i) or (ii) above shall be that of the Issuer or Trustee, as appropriate); and

(2) the provider's rating by either Moody's or S&P is withdrawn or suspended or falls below "A-" or "A3" by S&P or Moody's, as appropriate, the provider must, at the direction of the Issuer or the Bond Trustee, within 10 days of receipt of such direction, repay

the principal of and accrued but unpaid interest on the investment, in either case with no penalty or premium to the Issuer or Bond Trustee;

(h) The investment agreement shall state and an opinion of counsel shall be rendered that the Bond Trustee has a perfected first priority security interest in the Permitted Collateral, any substituted collateral and all proceeds thereof (in the case of bearer securities, this means the trustee is in possession); and

(i) the investment agreement must provide that if, during its term:

(1) the provider shall default in its payment obligations, the provider's obligations under the investment agreement shall, at the direction of the Issuer or the Bond Trustee, be accelerated and amounts invested and accrued but unpaid interest thereon shall be repaid to the Issuer or Bond Trustee, as appropriate;

(2) the provider shall become insolvent, not pay its debts as they become due, be declared or petition to be declared bankrupt, etc. ("event of insolvency"), the provider's obligations shall automatically be accelerated and amounts invested and accrued but unpaid interest thereon shall be repaid to the Issuer or Bond Trustee, as appropriate;

(3) the provider fails to perform any of its obligations under the investment agreement (other than obligations related to payment or rating) and such breach continues for ten (10) business days or more after written notice thereof is given by the Bond Trustee to the provider, it shall be an Event of Default; or

(4) a representation or warranty made by the provider proves to have been incorrect or misleading in any material respect when made, it shall be an Event of Default.

Permitted Collateral for Investment Agreements ("Permitted Collateral"):

(A) U.S. direct Treasury obligations;

(B) Senior debt and/or mortgage-backed obligations of GNMA, FNMA or FHLMC and other government-sponsored agencies backed by the full faith and credit of the U.S. government;

(C) Collateral levels must be 104% of the total principal deposited under the investment agreement for U.S. direct Treasury obligations, GNMA obligations and full faith and credit U.S. government obligations and 105% of the total principal deposited under the investment agreement for FNMA and FHLMC;

(D) The collateral must be held by a third party, segregated and marked to market at least weekly.

"Land" means the land subject to the Master Deed of Trust.

"Letter of Credit" means the Original Letter of Credit or, upon the effective date of any Substitute Letter of Credit, such Substitute Letter of Credit.

"Letter of Credit Period" means any period that a Letter of Credit is in effect with respect to the Bonds.

"Lien" means any mortgage or pledge of, security interest in or lien or encumbrance on any Property of any member of the Obligated Group in favor of, or which secures any Indebtedness or any other obligation of any member of the Obligated Group to any person other than another member of the Obligated Group, but specifically excluding subordination arrangements among creditors.

"Loan Agreement" means the Loan Agreement dated as of October 1, 2011, between the Issuer and the Alliance.

"Long-Term Indebtedness" means (i) all Indebtedness which, at the time of incurrence or issuance, has a final maturity or term greater than one year or which is renewable at the option of the obligor thereof for a term greater than one year from the date of original incurrence or issuance; and (ii) Short-Term Indebtedness which is incurred as interim financing and which is intended to be repaid out of the proceeds of other Long-Term Indebtedness, provided that any one of the applicable conditions described in the Master Indenture are met with respect to such Short-Term Indebtedness on the date of incurrence, assuming for purposes of compliance therewith that such Short-Term Indebtedness is Long Term Indebtedness characterized as Balloon Indebtedness for purposes of meeting any of the applicable conditions in the Master Indenture; provided, that, Long-Term Indebtedness shall not include (a) Non-Recourse Indebtedness or Subordinated Indebtedness; (b) current obligations payable out of current revenues, including current payments for the funding of pension plans and contributions to self insurance programs; (c) obligations under contracts for supplies, services or pensions, allocated to the current operating expenses of future years in which the supplies are to be furnished, the services rendered or the pensions paid; and (d) rentals payable under leases which are not properly capitalized under generally accepted accounting principles.

"Long-Term Interest Payment Date" means the first January 1 or July 1 next succeeding the Medium-Term Adjustment Date or Conversion Date, as the case may be, and each January 1 and July 1 thereafter until the earlier of payment of the Bonds or the date that the Weekly Rate Periods begin.

"Long-Term Rate Period" means any Medium-Term Rate Period and the Fixed Rate Period.

"Master Deed of Trust" means the Deed of Trust and Security Agreement dated as of February 1, 2000 from the Alliance to an individual, as trustee, granting a deed of trust lien on and a security interest in the Land and the other collateral described therein for the benefit of the Master Trustee, to secure the payment and performance of outstanding Obligations.

"Master Indenture" means the Amended and Master Trust Indenture dated as of February 1, 2000 between the Alliance and the Master Trustee, as it may from time to time be amended or supplemented in accordance with the terms thereof.

"Master Trustee" means The Bank of New York Mellon Trust Company, N.A., or any successor trustee under the Master Indenture.

"Maximum Annual Debt Service" of the Obligated Group means the highest annual Debt Service Requirement of the Obligated Group for the current or any succeeding Fiscal Year during the remaining term of all outstanding Obligations.

"Maximum Guaranty Liability" of a person as of any date means the greater of either (i) or (ii) below:

(i) the greater of (A) or (B) as of such date:

(A) the outstanding amount of all Obligations issued by such person or

(B) the fair market value of all property acquired, in whole or part, with the proceeds of such Obligations by such person.

(ii) The greatest of the Fair Value Net Worth of such person as of (1) the latest fiscal year-end of such person, (2) each fiscal quarter-end of such person thereafter occurring on or prior to the date of the determination of Maximum Guaranty Liability, (3) the date on which enforcement of the pertinent Cross Guarantee is sought, and (4) the date on which a case under the U.S. Bankruptcy Code is commenced with respect to any Obligated Issuer.

"MBIA" means MBIA Insurance Corporation and its successor or successors, as insurer of certain Related Bonds.

"Medium-Term Rate Period" means any period of time from one year to five years as determined by the Remarketing Agent pursuant to the Bond Indenture.

"Moody's" means Moody's Investors Service, Inc., its successors and assigns; and if such corporation shall be dissolved or liquidated or shall no longer perform the function of a municipal securities rating agency, "Moody's" shall be deemed to refer to any other recognized municipal securities rating agency designated by the Alliance.

"Net Operating Revenues" of a person means, with respect to any period of time, operating revenues less estimated contractual allowances, free care, discounts and bad debt expense, all determined, except as is specifically provided in the Master Indenture, in accordance with generally accepted accounting principles.

"Net Property, Plant and Equipment" means the Value of all Property, Plant and Equipment less accumulated depreciation.

"Non-Recourse Indebtedness" means any Indebtedness secured by a Lien on Property of any Obligated Issuer, liability for which is effectively limited to the Property subject to such Lien, with no recourse, directly or indirectly, to any other Property of any Obligated Issuer.

"Note" means any note issued under the Master Indenture by an Obligated Issuer to evidence Long-Term Indebtedness or Short-Term Indebtedness incurred pursuant to the terms of the Master Indenture.

"Notice by Mail" or "notice" of any action or condition "by Mail" means a written notice meeting the requirements of the Bond Indenture mailed by first-class mail, postage prepaid, to the Holders of specified Bonds at the addresses shown in the Bond Register. If, because of the temporary or permanent suspension of mail service or for any other reason, it is impossible or impracticable to mail any such notice in the manner described, then such notification in lieu thereof as shall be made with the approval of the Bond Trustee shall constitute a sufficient notice.

"Obligated Group" means all Obligated Issuers.

"Obligated Group Agent" means the Alliance and any successor Obligated Group Agent appointed pursuant to the Master Indenture.

"Obligated Issuer" means (i) the Alliance, Blue Ridge Medical Management Corporation, Norton Community Hospital, Smyth County Community Hospital and each other person which becomes an Obligated Issuer in accordance with the provisions of the Master Indenture, whether or not such person has issued any obligations thereunder, and which has not withdrawn from the Obligated Group pursuant to the Master Indenture, and (ii) when used in respect of any particular Obligation or other Indebtedness, means the obligor thereunder.

"Obligations" means all Notes and Indenture Guaranties issued under the Master Indenture, any lease, contractual agreement to pay money or other obligations of any Obligated Group Member issued thereunder and any additional forms of Obligations created pursuant to the Master Indenture.

"Officer's Certificate" means a certificate signed, in the case of a corporation, by the Chairman, Vice Chairman, President or Chief Financial Officer or, in the case of a certificate delivered by any other person, the chief executive or chief financial officer of such person, in either case whose authority to execute such certificate shall be evidenced to the satisfaction of the Master Trustee. When an Officer's Certificate is required under the Master Indenture to set forth matters relating to one or more Obligated Issuers, such Officer's Certificate may be given in reliance upon another certificate, or other certificates, and supporting materials, if any, provided by any duly authorized officer of the applicable Obligated Issuer.

"Opinion of Bond Counsel" means an opinion in writing signed by an attorney or firm of attorneys experienced in the field of municipal bonds whose opinions are generally accepted by purchasers of municipal bonds.

"Opinion of Counsel" means a written opinion of Counsel, who may (except as otherwise expressly provided in the Loan Agreement or the Bond Indenture) be counsel for the Issuer or the Alliance or both.

"Original Letter of Credit" means the Letter of Credit delivered by the Bank to the Bond Trustee on the date of original issuance of the Bonds in accordance with the Loan Agreement, and all amendments, modifications and supplements thereto.

"Paying Agent" means the bank or banks, if any, designated pursuant to a Related Bond Indenture to receive and disburse the principal of and interest on any Related Bonds or designated pursuant to the Master Indenture to receive and disburse the principal of and interest on any Obligations.

"Permitted Liens" means the Master Indenture, all Related Financing Documents and, as of any particular time:

(i) Any lien from any member of the Obligated Group to any other member of the Obligated Group;

(ii) Any judgment lien or notice of pending action against any member of the Obligated Group so long as (1) such judgment or pending action is being contested and execution thereon has been stayed or the period for responsive pleading or appeal has not lapsed, or (2) in the absence of such contest, neither the pledge and security interest of this Indenture nor any Property of any member of the Obligated Group will be materially impaired or subject to material loss or forfeiture;

(iii) (A) Rights reserved to or vested in any municipality or public authority by the terms of any right, power, franchise, grant, license, permit or provision of law affecting any Property, to (1) terminate such right, power, franchise, grant, license or permit, provided that the exercise of such right would not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof, or (2) purchase, condemn, appropriate or recapture, or designate a purchaser of, such Property; (B) any liens (or deposits to obtain the release of such liens) on any Property for taxes, assessments, levies, fees, water and sewer charges, and other governmental and similar charges and any liens of mechanics, materialmen, laborers, suppliers or vendors for work or services performed or materials furnished in connection with such Property, which are not due and payable or which are not delinquent or which, or the amount or validity of which, are being contested and execution thereon is stayed; (C) easements, rights-of-way, servitudes, restrictions and other minor defects, encumbrances, and irregularities in the title to any Property which do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; (D) rights reserved to or vested in any municipality or public authority to control or regulate any Property or to use such Property in any manner, which rights do not, in the opinion of the Obligated Group Agent, materially impair the use of such Property or materially and adversely affect the value thereof; and (E) to the extent that it affects title to any Property, the Master Indenture;

(iv) Any lease which relates to Property of the Obligated Group which is of a type that is customarily the subject of such leases, including but not limited to any leasehold interest required under any Related Financing Documents, leases with respect to office space for physicians and educational institutions, food service facilities, gift shops and radiology or other hospital-based specialty services, pharmacy and similar departments and statutory landlord's liens with respect to such leases;

(v) Any Lien securing Indebtedness provided such Lien also secures all Obligations (other than Obligations representing Subordinated Indebtedness or Non-Recourse indebtedness) on a parity basis;

(vi) Any Lien arising by reason of good faith deposits in connection with leases of real estate, bids or contracts (other than contracts for the payment of money), deposits by any member of the Obligated Group to

secure public or statutory obligations, or to secure, or in lieu of, surety, stay or appeal bonds, and deposits as security for the payment of taxes or assessments or other similar charges;

(vii) Any Lien arising by reason of deposits with, or the giving of any form of security to, any governmental agency or any body created or approved by law or government regulation for any purpose at any time as required by law or governmental regulation as a condition to the transaction of any business or the exercise of any privilege or license, or to enable any member of the Obligated Group to maintain self insurance or to participate in any funds established to cover any insurance risks or in connection with workers compensation, unemployment insurance, pension or profit sharing plans or other similar social security plans, or to share in the privileges or benefits required for companies participating in such arrangements;

(viii) Any Lien arising by reason of an Escrow Deposit;

(ix) (A) Any Lien in favor of a trustee or the holder of a Note on the proceeds of Indebtedness or cash or investments deposited with such trustee and acquired with such proceeds prior to the application of such proceeds or cash or investments and (B) Liens in favor of a trustee, including the Master Trustee, to secure obligations to compensate, reimburse or indemnify such trustees;

(x) Any Lien on moneys deposited by patients or others with any member of the Obligated Group as security for or as prepayment for the cost of patient care;

(xi) Any Lien on Property received by any member of the Obligated Group through gifts, grants or bequests, such Lien being due to restrictions on such gifts, grants or bequests of property or the income thereon;

(xii) Statutory rights of the United States of America by reason of federal funds made available under 42 U.S.C. §§ 291 *et seq.* and similar rights under other federal and state statutes;

(xiii) Liens existing at the time of a Consolidation or Merger permitted under the Master Indenture, on the date of acquisition of any Property or at the time a person becomes an Obligated Issuer; provided that no such Lien (or the amount of indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of any member of the Obligated Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified shall be offered as security for all Obligations hereunder;

(xiv) Any Lien described in Exhibit A to the Master Indenture, provided that no such Lien (or the amount of indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of any member of the Obligated Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified otherwise qualifies as a Permitted Lien under the Master Indenture;

(xv) A security interest in any funds or accounts established pursuant to the provisions of any Related Financing Documents;

(xvi) Liens in the form of purchase money security interests in Property financed with the proceeds of Indebtedness secured thereby;

(xvii) Liens securing any Indebtedness permitted under the Master Indenture, provided that the Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that not more than 20% of the Value of all Net Property Plant and Equipment of the Obligated Group would be subject to a Lien (excluding any purchase money security interest permitted under subsection (xvi) above and the Lien created under the Master Deed of Trust for the purpose of making such calculation);

(xviii) Liens on accounts receivable arising as a result of sale of such accounts receivable with recourse, provided that such liens shall be limited to 25% of net accounts receivable outstanding; and

(xix) Options granted by any member of the Obligated Group to others to purchase real property or other assets of such member; provided, however, that the sale pursuant to such option would be permitted under the conditions described in the Master Indenture.

(xx) Liens on any Property that is not encumbered by the Master Deed of Trust so long as the aggregate amount secured by such Liens does not exceed $5,000,000.

"Pledged Bonds" means any Bonds purchased with the proceeds of a drawing under and in accordance with the provisions of the Letter of Credit until such time as such Bonds are released from the security interest created by the Reimbursement Agreement in accordance with the provisions thereof.

"Proceeds" means "proceeds" as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction or under other relevant law and, in any event, shall include, but shall not be limited to, (i) any and all proceeds of any insurance, indemnity, warranty or guaranty payable to any Obligated Issuer from time to time, and claims for insurance, indemnity, warranty or guaranty effected or held for the benefit of the Corporation, with respect to any of the Collateral, (ii) any and all payments (in any form whatsoever) made or due and payable to the any Obligated Issuer from time to time in connection with any requisition, confiscation, condemnation, seizure or forfeiture of all or any part of the Collateral by any Government Authority (or any person acting under color of Government Authority) and (iii) any and all other amounts from time to time paid or payable under or in connection with any of the Collateral.

"Projected Debt Service Coverage Ratio" means for any future period of time, the ratio determined by dividing projected Total Income Available for Debt Service for such period by Maximum Annual Debt Service of the Obligated Group.

"Property" means any and all rights, titles and interests in and to any and all assets of a person, including all real or personal property, all tangible or intangible property, and all cash, wherever such assets are situated.

"Property, Plant and Equipment" means all Property which is classified as property, plant and equipment under generally accepted accounting principles.

"Proposed Tax Conversion Date" shall have the meaning set forth in the Bond Indenture.

"Rate Period" or "Rate Periods" means any of (a) the Weekly Rate Periods, (b) the Medium-Term Rate Periods or (c) the Fixed Rate Period.

"Rating Agency" means, severally or collectively, if applicable (i) Standard & Poor's Ratings Group and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding under the Master Indenture or any Related Bonds issued and outstanding pursuant to any Related Financing Documents, (ii) Moody's Investors Service, Inc. and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding under the Master Indenture or any Related bonds issued and outstanding pursuant to any Related Financing Documents, and (iii) Fitch's IBCA Inc. and any successor thereto, if it has assigned a rating to any Obligation issued and outstanding pursuant to any Related Financing Documents. If any such Rating Agency shall no longer perform the functions of a securities rating service for whatever reason, the term "Rating Agency" shall thereafter be deemed to refer to the others, but if both of the others shall no longer perform the functions of a securities rating service for whatever reason, term "Rating Agency" shall thereafter be deemed to refer to any other nationally recognized rating service or services as shall be designated in writing by the Obligated Group Agent to the Master Trustee; provided that such designee shall not be unsatisfactory to the Master Trustee.

"Receivables" means any "Account" as such term is defined in the Uniform Commercial Code as in effect in any relevant jurisdiction and in any event shall include, but not be limited to, all of any Obligated Issuer's rights to payment for goods (including, without limitation, steam and electricity) sold or leased, or for services performed, by such Obligated Issuer, whether now in existence or arising from time to time hereafter, including, without limitation, rights evidenced by an account, note, contract, security agreement, chattel paper, or other evidence of indebtedness or security, together with (i) all security pledged, assigned, hypothecated or granted to or held by any

Obligated Issuer to secure the foregoing, (ii) all of such Obligated Issuer's right, title and interest in and to any goods (including, without limitation, steam and electricity), the sale of which gave rise thereto, (iii) all guarantees, endorsements and indemnifications on, or of, any of the foregoing, (iv) all powers of attorney for the execution of any evidence of indebtedness or security or other writing in connection therewith, (v) all books, correspondence, credit files, records, ledger cards, invoices, and other papers relating thereto, including without limitation all similar information stored on a magnetic medium or other similar storage device and other papers and documents in the possession or under the control of any Obligated Issuer or any computer bureau from time to time acting for such Obligated Issuer, (vi) all evidences of the filing of financing statements and other statements and the registration of other instruments in connection therewith and amendments thereto, notices to other creditors or secured parties, and certificates from filing or other registration officers, (vii) all credit information, reports and memoranda relating thereto, and (viii) all other writings related in any way to the foregoing.

"Record Date" means (a) during Weekly Rate Periods, the Business Day preceding any Interest Payment Date, and (b) during any Medium-Term Rate Periods or Fixed Rate Periods, the fifteenth day of the month preceding any Interest Payment Date.

"Redemption Date" when used with respect to any Bond to be redeemed means the date on which it is to be redeemed pursuant hereto.

"Redemption Price" when used with respect to any Bond to be redeemed means the price at which it is to be redeemed pursuant thereto.

"Regularly Scheduled Qualified Swap Payments" means the regularly scheduled payments under the terms of an Hedge Agreement which are due or receivable absent any termination, default or dispute in connection with such Hedge Agreement.

"Reimbursement Agreement" means the Reimbursement Agreement dated as of the date hereof among the Obligated Group, the Bank and other Lenders Parties thereto, including any amendments or supplements thereto; and upon the effective date of any Substitute Letter of Credit, "Reimbursement Agreement" shall mean a similar agreement, if any, between the issuer of such Substitute Letter of Credit and the Alliance.

"Related Bond Indenture" means any indenture, bond resolution or other comparable instrument pursuant to which a series of Related Bonds is issued.

"Related Bond Issuer" means the Government Issuer of any issue of Related Bonds.

"Related Bond Trustee" means the trustee and its successors in the trust created under any Related Bond Indenture, and if there is no such trustee, shall mean the Related Bond Issuer.

"Related Bonds" means the revenue bonds, notes, other evidences of indebtedness or any other obligations issued by a Government Issuer, pursuant to a single Related Bond Indenture, the proceeds of which are loaned or otherwise made available to an Obligated Issuer in consideration of the execution, authentication and delivery of a Note to or for the order of such Government Issuer.

"Related Financing Documents" means:

(a) in the case of any Note, (i) all documents, including any Related Bond Indenture, pursuant to which the proceeds of the Note are made available to an Obligated Issuer, the payment obligations evidenced by the Note are created and any security for the Note (if permitted under this Indenture) is granted, and (ii) all documents creating any additional payment or other obligations on the part of an Obligated Issuer which are executed in favor of the Holder in consideration of the Note proceeds being loaned or otherwise made available to the Obligated Issuer;

(b) in the case of any Indenture Guaranty, all documents creating the indebtedness being guaranteed pursuant to the Indenture Guaranty and providing for the loan or other disposition of the proceeds of the

indebtedness and all documents pursuant to which any security for the Indenture Guaranty (if permitted under the Master Indenture) is granted; and

(c) in the case of Indebtedness other than Notes and Indenture Guaranties, all documents relating thereto which are of the same nature and for the same purpose as the documents described in clauses (a) and (b) above.

"Revenues" means all revenues, income, receipts and other money received or accrued by or on behalf of any Obligated Issuer from any source whatsoever, including, without limitation, proceeds derived from (i) insurance except where otherwise provided herein, (ii) all accounts and assignable general intangibles now owned or hereafter acquired by any Obligated Issuer, and all proceeds therefrom whether cash or noncash, all as defined in Article 9 of the Uniform Commercial Code, as enacted by the State of Tennessee, (iii) the sale of goods, inventory and other tangible and intangible property, (iv) agreements respecting Medicare, Medicaid and Blue Cross or similar or successor programs, and (v) all gifts, grants, bequests, contributions and donations made to any Obligated Issuer, including the income and profits therefrom.

"S&P" means Standard & Poor's Rating Group, a division of McGraw-Hill Financial Services Company, its successors and assigns; and if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a municipal securities rating agency, Standard & Poor's Corporation shall be deemed to refer to any other nationally recognized municipal securities rating agency designated by the Alliance.

"Series" means, individually, the Series 2011A Bonds, the Series 2011B Bonds, the Series 2011C Bonds, the Series 2011D Bonds or the Series 2011E Bonds.

"Series 2011 Obligations" means the Mountain States Health Alliance Notes being issued by the Alliance under the Master Indenture in connection with the issuance of the Bonds.

"Short-Term Indebtedness" means all Indebtedness other than Long-Term indebtedness.

"Subordinated Indebtedness" means any promissory note, guaranty, lease, contractual agreement to pay money or other obligation of any Obligated Issuer which is expressly made subordinate and junior in right of payment of principal of, redemption premium, if any, and interest on, (i) all Obligations issued pursuant to the Master Indenture, and (ii) all other obligations of the Obligated Group under the Master Indenture, on terms and conditions which substantially require that (1) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness, unless full payment of all amounts when due and payable upon maturity of Obligations issued under the Master Indenture have been made or duly provided for in accordance with the terms of such Obligations; (2) no payment on account of principal of, redemption premium, if any, or interest on such Subordinated Indebtedness shall be made, nor shall any property or assets be applied to the purchase or other acquisition or retirement of such Subordinated Indebtedness if, at the time of such payment or application, or immediately after giving effect thereto, (i) there shall exist a default in the payment of the principal of, redemption premium, if any, or interest on any Obligations (whether at maturity or upon mandatory redemption), or (ii) there shall have occurred an Event of Default with respect to any Obligations, as defined therein and in this Indenture, and such Event of Default shall not have been cured or waived or shall not have ceased to exist; and (3) in the event that any Subordinated Indebtedness is declared or otherwise becomes due and payable because of the occurrence of an event of default with respect thereto, (x) the Holders at such time shall be entitled to receive payment in full thereon before the holders of the Subordinated Indebtedness shall be entitled to receive any payment on account of such Subordinated Indebtedness as a result of such event of default, and (y) no holder of Subordinated Indebtedness, or a trustee acting on such holder's behalf, shall be entitled to exercise any control over proceedings to enforce the terms and conditions of the Master Indenture.

"Tax-Exempt Bonds" means, together, the Tennessee Bonds and the Virginia Bonds.

"Tax-Exempt Organization" means a person organized under the laws of the United States of America or any state thereof which is an organization described in Section 501(c)(3) of the Code, which is exempt from federal

income taxes under Section 501(a) of the Code, and which is not a "private foundation" within the meaning of Section 509(a) of the Code, or corresponding provisions of federal income tax laws from time to time in effect.

"Termination Date" means the stated expiration date of the Letter of Credit or the immediately preceding Business Day if such date is not a Business Day but shall not include the expiration date of the Letter of Credit due to a conversion to the Fixed Rate.

"Total Income Available for Debt Service" means, as to any period, (a) the aggregate of Income Available for Debt Service of each member of the Obligated Group for such period, determined in such a manner that no portion of Income Available for Debt Service of any member of the Obligated Group is included more than once.

"Total Net Operating Revenues" means, as to any period, the aggregate of Net Operating Revenues of each member of the Obligated Group for such period, determined in such a manner that no portion of Net Operating Revenues of any member of the Obligated Group is included more than once.

"Unrestricted Liquid Funds" as of any date means the aggregate of the unrestricted and unencumbered/unpledged cash and unrestricted and unencumbered/unpledged liquid securities (valued at fair market value) of the Obligated Group as of such date (including board-designated funds) from which there shall be subtracted each of the following: (i) the value of all self-insured professional and general liability insurance obligations of the Obligated Group determined by an independent actuary as of such date, (ii) any funds held by the lender or trustee with respect to any Long Term Indebtedness (including any debt service reserve fund, any debt service or bond fund or any construction or project fund), (iii) any proceeds drawn from a line of credit, liquidity facility or other similar facility and (iv) any grantor or donor restricted funds.

"Value," when used in connection with any Property, means either (a) Book Value, or (b) at the election of the Obligated Group Agent evidenced by an Officer's Certificate delivered to the Master Trustee, the aggregate fair market value of such Property, as reflected in the most recent written report of an appraiser selected by the Obligated Group Agent and, in the case of real property, who or which is a member of the American Institute of Real Estate Appraisers (MAI), delivered to the Master Trustee (which report shall be dated not more than three years prior to the date as of which value is to be calculated) (i) increased or decreased by the cost of any Property acquired, or the fair market value of any Property disposed of, since the date of such report and (ii) increased or decreased by a percentage equal to the aggregate percentage increase or decrease in the Construction Index from the date of such report to the date as of which value is to be calculated.

"Variable Rate Indebtedness" means any portion of Indebtedness the interest rate on which fluctuates subsequent to the time of incurrence.

SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE

Each Obligation will be issued pursuant to the Master Indenture and will entitle each holder thereof to the protection of the covenants, restrictions and other obligations imposed upon the Corporation and each Obligated Issuer by the Master Indenture and the security provided for therein.

Accounting Principles

Where the character or amount of any asset or liability or item of income or expense is required to be determined or any consolidation, combination or other accounting computation is required to be made for the purposes of the Master Indenture or any agreement, document or certificate executed and delivered in connection with or pursuant to the Master Indenture, such determination or computation shall be done in accordance with generally accepted accounting principles in effect on (i) the date of the delivery of the Master Indenture, or (ii) at the election of the Obligated Group Agent, as specified in an Officer's Certificate delivered to the Master Trustee, the date such determination or computation is made for any purpose of the Master Indenture, such accounting principles, to the extent applicable, consistently applied; provided that intercompany balances and liabilities among

the Obligated Issuers shall be disregarded and that the requirements set forth in this paragraph shall prevail, if inconsistent with generally accepted accounting principles. In the event that the fiscal year of any Obligated Issuer ends on a date other than the last day of a Fiscal Year, the character or amount of any asset or liability or item of income or expense of such Obligated Issuer for its fiscal year ending within any Fiscal Year under consideration shall be deemed to be the character or amount of the appropriate asset or liability or item of income or expense for such Fiscal Year. For purposes of calculating Total Income Available for Debt Service and Total Net Operating Revenues for any period, if any Obligated Issuer shall have become a member of the Obligated Group during such period, such calculations shall be made assuming that such Obligated Issuer became a member of the Obligated Group at the beginning of such period.

Master Indenture Obligations

Each Obligated Issuer is permitted to issue one or more series of Obligations under the Master Indenture on which all Obligated Issuers will be jointly and severally liable. The terms of each Obligation shall be set forth in a Supplemental Indenture.

The principal of, premium, if any, and interest on the Obligations shall be payable in any currency of the United States of America which is legal tender for the payment of public and private debts. Such payment shall be made at the principal corporate trust office of the Master Trustee or, if an Obligated Issuer so elects, by check, draft or wire transfer to such Holder. In the case of all payments made directly to a Holder, the Obligated Issuer shall give notice of such payment to the Master Trustee concurrently with the making thereof.

Each Obligated Issuer, jointly and severally, unconditionally guarantees to the Holders of the Obligations and to the Master Trustee the due and punctual payment of the principal of, and interest on, the Obligations and all other amounts due and payable under the Master Indenture; provided, however, that the maximum aggregate liability of each Obligated Issuer, as of any date, shall be its Maximum Guaranty Liability as of such date.

Each Obligated Issuer shall be subrogated to all rights of the Holders of the Obligations and the Master Trustee against the other Obligated Issuers in respect of any amounts paid pursuant to the Master Indenture.

If any person ceases to be an Obligated Issuer, such person shall cease to be a "Cross Guarantor" under the Master Indenture, and its Obligations as such shall be terminated and released; provided, however, that the foregoing provision is inapplicable (i) if such person ceases to be an Obligated Issuer as a result of a transaction which is prohibited by the terms of the Master Indenture or (ii) if, at the time such person would otherwise have been released under the provisions of this paragraph, there has occurred and is continuing a default in the payment of principal, or interest, on any Obligation.

If an Obligated Issuer is called upon to make a payment under its Cross Guarantee, each of the Obligated Issuers shall contribute to such paying Obligated Issuer their pro rata share, determined pursuant to the Master Indenture, of the amount of such payment.

All Obligations shall be executed for and on behalf of an Obligated Group Member by the officer as specified in the Master Indenture or such other officer designated in writing. A resolution of the Governing Body of the Obligated Group Agent shall also be joined thereto. Further, each Obligation shall be manually authenticated, in the form provided in the Master Indenture, by an authorized signer of the Master Trustee, without which authentication no Obligation shall be valid or entitled to the benefits of the Master Indenture.

The Master Trustee shall maintain at its principal corporate trust office a registration book relating to Obligations of the Obligated Group. These registration books shall contain (i) the names and addresses of Holders of Obligations, and (ii) any other information which may be necessary for the proper discharge of the Master Trustee's duties under the Master Indenture. The Supplemental Indenture, providing for the issuance thereof, shall govern the transfer or exchange of any Obligation.

If any Obligation is mutilated, lost, stolen or destroyed, the Holder thereof shall be entitled to the issuance of a substitute Obligation only as follows:

(i) In the case of a lost, stolen or destroyed Obligation, the Holder shall: provide notice of the loss to the Obligated Group Agent, or to the Master Trustee; request the issuance of a substitute Obligation before the Obligated Group Agent receives notice of the transfer of the original Obligation to a bona fide purchaser for value without notice; provide indemnity to the Master Trustee against any and all claims arising out of, or otherwise related to, the issuance of substitute Obligations; and shall surrender any Obligation which have not been lost, stolen or destroyed and provide evidence of the ownership of the affected Obligation and the loss, theft or destruction thereof;

(ii) In the case of a mutilated Obligation the Holder shall: surrender the Obligation to the Master Trustee for cancellation; and provide indemnity to the Master Trustee against any and all claims arising out of, or otherwise related to, the issuance of substitute Obligations.

Every substituted Obligation shall constitute an additional contractual obligation of the Obligated Group, whether or not the Obligation alleged to have been destroyed, lost or stolen shall be at any time enforceable by anyone, and shall be entitled to all the benefits of the Master Indenture equally and proportionately with any and all other Obligations, unless the Obligation alleged to have been destroyed, lost or stolen shall be at any time enforceable by a bona fide purchaser for value without notice.

The preceding provisions regarding substitute Obligations are exclusive with respect to the replacement or payment of mutilated, destroyed, lost or stolen Obligations and shall preclude any and all other rights or remedies, notwithstanding any law or statute existing or later enacted to the contrary.

The Master Trustee shall establish and maintain a revenue or similar debt service fund for the purpose of accumulating and paying amounts due on outstanding Obligations (i) if the applicable Supplemental Indenture provides for the making of deposits directly with the Master Trustee in respect of an Obligation, or (ii) upon the occurrence of an Event of Default under the Master Indenture and the exercise of any remedies by the Master Trustee for the benefit of all Holders of outstanding Obligations. All money held in any fund established under the Master Indenture, in the case of (i) above, shall, upon written request and direction of the Obligated Group Agent, be invested in Investment Securities, and any money realized by the Master Trustee in the case of (ii) above, shall be invested by the Master Trustee, without need of any further authorization or direction, only in Government Obligations with maturities not in excess of ninety days, unless the Master Trustee is otherwise directed by Holder. The Master Trustee shall not be liable or responsible for any loss resulting from any such investment.

Any Obligated Issuer and the Master Trustee may enter into a Supplemental Indenture to create an Obligation issued under the Master Indenture. The Supplemental Indenture shall (i) with respect to Obligations created thereby, set forth the date thereof, and the date or dates on which principal of, premium, if any, and interest on such Obligations shall be payable, and (ii) provide for the form of such Obligations and shall contain such other terms and provisions as shall not be inconsistent with the provisions of the Master Indenture.

Simultaneously with or prior to the execution, authentication and delivery of the Obligations pursuant to the Master Indenture:

(a) All requirements and conditions to the issuance of such Obligations, if any, set forth in the Master Indenture and the Supplemental Indenture shall have been complied with and satisfied;

(b) The applicable Obligated Issuer or the Obligated Group Agent shall have delivered to the Master Trustee such opinions, certificates, proceedings, instruments and other documents as the Master Trustee or the Related Bond Issuer, if any, may reasonably request;

(c) The requirements of the Master Indenture with respect to the incurrence of Additional Indebtedness shall have been satisfied if such Obligations constitute Indebtedness;

(d) Each Supplemental Indenture shall specify the purpose or purposes for which such Obligations are being issued, which may be any purpose within the corporate power of the applicable Obligated Issuer; and

(e) The Obligated Group Agent shall have delivered to the Master Trustee an opinion of counsel, regarding the Securities Act of 1933 and the Trust Indenture Act of 1939, as required pursuant to the Master Indenture.

Security For Obligations

As security for the payment and performance of all outstanding Obligations, the Obligated Issuers shall grant the Master Trustee a security interest in (i) all money and Investment Securities which may at any time be held by the Master Trustee in any fund or account which may be established by the Master Trustee under the Master Indenture in connection with the administration of the trusts created thereby, (ii) all Gross Receipts, (iii) all Receivables, (iv) all Inventory, (v) all Equipment, (vi) all General Intangibles, (vii) all Contracts and all Contract Rights, (viii) all amounts from time to time held in any checking, savings, deposit or other account of any Obligated Issuer, (ix) all Government Approvals, provided, that any Government Approval which by its terms or by the operation of law would become void, voidable, terminable or revocable if mortgaged, pledged or signed under the Master Indenture or if a security interest therein were granted thereunder or expressly accepted and excluded from the security interest hereby granted to the extent necessary so as to avoid such voidness, voidability, terminability or revocability, (x) all Fixtures, including but not limited to those now or hereafter attached to, placed on or incorporated in the Land, (xi) all Revenues, (xii) without limiting the generality of the foregoing, all other personal property, goods, Instruments, Investment Property, Chattel Paper, Documents, credits, claims, demands and assets of any Obligated Issuer, whether now existing or hereafter acquired from time to time, and (xiii) any and all additions and accessions to any of the foregoing, all improvements thereto, all substitutions and replacements therefor and all products and Proceeds thereof (all of the above collectively, the "Collateral"), to have and to hold in trust for the benefit of the Holders from time to time of all Obligations issued and outstanding under the Master Indenture, without preference or priority of any one Obligation over any other Obligation except as otherwise expressly provided therein. The security interest granted to the Master Trustee pursuant to the Master Indenture extends to all Collateral of the kind which is subject to such security interest which any Obligated Issuer may acquire at any time during the continuation of the Master Indenture, whether such Collateral is in transit or in such Obligated Issuer, the Issuer's or any other person's constructive, actual or exclusive occupancy or possession.

To further secure the payment of and performance under all outstanding Obligations, the Corporation has, on even date herewith, executed and delivered to the Master Trustee the Master Deed of Trust.

If (i) in any Fiscal Year beginning with the Fiscal Year ending June 30, 2006, the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.50 to 1, (ii) the Obligated Group is not in compliance with the liquidity covenant described under the caption "Liquidity Covenant" herein, or (iii) an Event of Default has occurred and is continuing, the Obligated Group Agent shall cause a special trust fund (the "Revenue Fund") to be created with one or more banking institutions and each Obligated Issuer shall on a daily basis deposit all of its Gross Receipts therein.

The Obligated Group Agent shall cause each banking institution with which the Revenue Fund has been established to enter into a written depository agreement, which shall be satisfactory in form and substance to the Master Trustee and shall be in substantially the form of such agreement heretofore delivered to the Master Trustee (or with such changes therein as shall have been approved by the Holders of not less than 75% in aggregate principal amount of Obligations then outstanding) pursuant to which such banking institution shall agree to hold any and all Gross Receipts from time to time on deposit with such banking institution as assets of a trust for the Holders of the Obligations and to transfer such Gross Receipts to the Master Trustee upon receipt from the Master Trustee of a notice stating that delivery of such Gross Receipts is required pursuant to the Master Indenture. Prior to its receipt of a request from the Master Trustee, any Obligated Group member may transfer or expend all or any part of its Gross Receipts free of any security interest, subject, however, to the provisions of the Master Indenture. Deposits of Gross Receipts shall be made into the Revenue Fund on a daily basis, insofar as practicable, for the benefit of the Master Trustee and the Holders of the Obligations. Upon the request of the Obligated Group Agent, the Master

Trustee will provide to such agent a written certifications as to whether there is currently outstanding a request from the Master Trustee.

Each Obligated Issuer agrees that except as may be otherwise provided in the Master Indenture, it will not pledge or grant a security interest in any of the Gross Receipts.

Each Obligated Issuer agrees that, if an Event of Default shall have occurred and be continuing, it will, upon request of the Master Trustee, deliver or direct to be delivered to the Master Trustee all Gross Receipts until such Event of Default has been cured, such Gross Receipts to be applied in accordance with the Master Indenture.

The Master Trustee shall establish and maintain a revenue or similar debt service fund hereunder for the purpose of accumulating and paying amounts due on outstanding Obligations (i) if the applicable Supplemental Indenture specifically provides for the making of deposits directly with the Master Trustee in respect of an Obligation, or (ii) upon the occurrence of an Event of Default and the exercise of any remedies by the Master Trustee for the benefit of all Holders of outstanding Obligations; provided, however, if neither (i) nor (ii) are at the time applicable but deposits to the Revenue Fund are then required under subsection (a) above, the Obligated Group Agent may deposit the Gross Receipts with one or more banking institutions (other than the Master Trustee) and such revenues shall, upon the request and direction of the Obligated Group Agent, be invested in Investment Securities. In the case of (i) above, deposits to any such fund and payments therefrom shall be made in accordance with the terms and provisions of the applicable Supplemental Indenture for the making of deposits into and payments from such fund. In the case of (ii) above, any moneys realized by the Master Trustee upon the exercise of any such remedies shall be applied in accordance with the provisions of the Master Indenture. All money held at any time in any fund in the case of (i) above, shall, upon written request and direction of the Obligated Group Agent, be invested in Investment Securities and any money realized by the Master Trustee in the case of (ii) above, shall be invested by the Master Trustee, without need of any further authorization or direction, only in Government Obligations having maturities not in excess of 90 days, unless the Master Trustee is otherwise directed by Holders in the manner provided in the Master Indenture.

Persons Becoming Obligated Issuers; Withdrawal from Obligated Group

The Master Indenture permits persons other than the Corporation to become members of the Obligated Group subject to the satisfaction of certain conditions. The conditions include the following:

First, such person shall execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Obligated Group Agent, containing (i) the agreement of such person to become an Obligated Issuer under the Master Indenture and thereby to become subject to compliance with all provisions of the Master Indenture pertaining to an Obligated Issuer, including the performance and observance of all covenants and obligations of an Obligated Issuer under the Master Indenture; (ii) the agreement of such person to consult with each other member of the Obligated Group prior to incurring any Obligations; and (iii) such other restrictions on the ability of such person to incur Obligations as shall be imposed by the Obligated Group. Such person shall execute and deliver to the Master Trustee such security agreements, financing statements and other documents as are necessary to grant to the Master Trustee a perfected lien in all Collateral in which such person has an interest.

Second, each instrument executed and delivered to the Master Trustee in accordance with the preceding paragraph shall be accompanied by an Officer's Certificate from the Obligated Group Agent to the effect that the Obligated Group Agent consents to such person becoming an Obligated Issuer and an opinion of Counsel to the effect that (a) the conditions contained in the Master Indenture relating to such person's membership in the Obligated Group have been satisfied; (b) under then existing law, such person becoming an Obligated Issuer will not subject any Obligation to the registration provisions of the Securities Act of 1933, as amended, or that such Obligation has been so registered if so required, or the qualification of the Master Indenture pursuant to the Trust Indenture Act of 1939, as amended, or that the Master Indenture has been so qualified if qualification is required; and (c) each such instrument has been duly authorized, executed and delivered by such person and constitutes a legal, valid and binding agreement, enforceable in accordance with its terms, except as limited by then-existing laws relating to bankruptcy and insolvency and other standards and customary legal exceptions.

If all amounts due or to become due on any outstanding Related Bond which bears interest that is not includable in gross income under the Code has not been paid to the holder thereof (or provision for such payment has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee shall receive an Opinion of Bond Counsel to the effect that under then existing law such person becoming an Obligated Issuer would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code.

As a further condition to a person becoming a member of the Obligated Group, the Master Trustee shall receive an Officer's Certificate from the Obligated Group Agent to the effect that (A) no Event of Default then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an Event of Default under the Master Indenture, and (B) either (1) if one dollar of Additional Indebtedness were incurred immediately following such person's admission, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) under the heading "Additional Long-Term Indebtedness" (assuming, for purposes of such certificate, that the Income Available for Debt Service and Indebtedness of such person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (2) such person becoming a member of the Obligated Group will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such membership, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such entry into the Obligated Group will be greater than the projected Debt Service Coverage Ratio for such Fiscal Years had such entry into the Obligated Group not occurred, and (C) immediately after such person's admission, the combined fund balance and net worth, as the case may be, of the Obligated Group is not less than 90% of such combined fund balance and net worth immediately prior to such admission, and (D) the Historical Pro Forma Debt Service Coverage Ratio of the Obligated Group (taking into account the admission of such person) for each of the two most recent Fiscal Years for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available was not less than 1.30:1.

As a further condition to a person becoming a member of the Obligated Group, the Master Trustee shall receive a Consultant's report to the effect that the Projected Debt Service Coverage Ratio of the Obligated Group (taking into account the admission of such person) for each of the two Fiscal Years following the admission of such person is not less than 1.30:1.

The Corporation shall not withdraw from the Obligated Group. No other Obligated Issuer may withdraw from the Obligated Group unless:

(i) If the Obligated Issuer is other than the Obligated Group Agent, the Obligated Group Agent consents to the withdrawal;

(ii) If all amounts due on any outstanding Related Bond which bears interest that is not includable in gross income under the Code have not been paid to the holder thereof (or provision for such payments has not been made in such manner as to have resulted in the defeasance of the Related Financing Documents), the Master Trustee shall have received an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law such person's withdrawal from the Obligated Group would not adversely affect the validity of such Related Bond or cause the interest payable on such Related Bond to become includable in gross income under the Code;

(iii) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that either (1) after giving effect to such withdrawal, if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) under the heading "Additional Long-Term Indebtedness," or (2) such person's withdrawal from the Obligated Group will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such withdrawal, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following withdrawal of such Obligated Issuer from the Obligated Group will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such withdrawal not occurred;

(iv) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that, immediately after the withdrawal of such person from the Obligated Group, no Event of Default then exists under the Master Indenture, nor to such officer's knowledge, does there then exist any event which, with the passage of time or giving of notice or both, would or might become an Event of Default; and

(v) The Master Trustee shall have received a Consultant's report to the effect that the Projected Debt Service Coverage Ratio of the Obligated Group (taking into account the withdrawal of such person) for each of the two Fiscal Years following the withdrawal of such person is not less than 1.3:1;

(vi) The Master Trustee shall have received an Officer's Certificate from the Obligated Group Agent to the effect that the Historical Pro Forma Debt Service Coverage Ratio of the Obligated Group (taking into account the withdrawal of such Obligated Issuer) for each of the two most recent Fiscal Years for which consolidated or combined financial statements reported upon an independent certified public Accountant are available was not less than 1.30 to 1; and

(vii) The Obligated Group Agent shall have received an opinion of Counsel to the effect that following such person's withdrawal from the Obligated Group no member of the Obligated Group will have any liability for the payment of any indebtedness of such person.

Upon compliance with the above conditions, the Master Trustee shall execute any documents reasonably requested by the withdrawing Obligated Issuer to evidence the termination of such Issuer's obligations under the Master Indenture, under any Supplemental Indenture and under all Obligations.

Short-Term Indebtedness

Each Obligated Issuer agrees that it will not incur, nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Short-Term Indebtedness unless immediately after the incurrence of such Short-Term Indebtedness:

(a) (i) the principal amount of all Short-Term Indebtedness of the Obligated Group then outstanding does not exceed 20% of the Total Net Operating Revenues for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, or

(ii) any such Short-Term Indebtedness could be incurred under the tests set forth in the Master Indenture (relating to Long-Term Indebtedness) treating such Short-Term Indebtedness as Long-Term Indebtedness, and

(b) For a period of not fewer than 15 consecutive days within each Fiscal Year, the Obligated Group shall reduce the aggregate principal amount of all outstanding Short-Term Indebtedness described in (a)(i) above to less than 5% of the Total Net Operating Revenues for the immediately preceding Fiscal Year.

Additional Long-Term Indebtedness

Each Obligated Issuer agrees that it will not incur nor permit any of its Restricted Affiliates to incur, any Additional Indebtedness constituting Long-Term Indebtedness unless such Long-Term Indebtedness consists of one or more of the following:

(a) Long-Term Indebtedness of any member of the Obligated Group, if prior to the incurrence thereof, there is delivered to the Master Trustee:

(i) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Pro Forma Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, was not less than 1.35; or

(ii) (A) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical Maximum Annual Debt Service Coverage Ratio for the most recent Fiscal Year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available, was not less than 1.25 and (B) a Consultant's report (or, in lieu thereof, an Officer's Certificate of the Obligated Group Agent if the Projected Debt Service Coverage Ratio described in this subsection (B) is 1.75 or greater) to the effect that the Projected Debt Service Coverage Ratio, taking the proposed Additional Indebtedness into account, (x) in the case of Additional Indebtedness (other than a Guaranty) to finance capital improvements, for each of the two Fiscal Years succeeding the date on which such capital improvements are expected to be in operation, or (y) in the case of Long-Term Indebtedness not financing capital improvements or in the case of a Guaranty, for each of the two Fiscal Years succeeding the date on which the Indebtedness or Guaranty is incurred, is not less than 1.40.

The requirements of (a)(ii)(A) and (B) will be deemed satisfied if (i) a Consultant's report filed with the Master Trustee states that applicable laws or regulations have prevented or will prevent the achievement of such debt service coverage ratios, (ii) the Obligated Group has generated Total Income Available for Debt Service in an amount which, in the opinion of such Consultant, the Obligated Group could reasonably have generated given such laws and regulations during the period affected thereby.

(b) Completion Indebtedness of any member of the Obligated Group without limit if there is delivered to the Master Trustee: (i) an Officer's Certificate of the applicable member of the Obligated Group stating that at the time the original Long-Term Indebtedness for the Facilities to be completed was incurred, such Obligated Group member had reason to believe that the proceeds of such Long-Term Indebtedness, together with other moneys then expected to be available, would provide sufficient moneys for the completion of such Facilities; (ii) a statement of an Architect or an expert setting forth the amount estimated to be needed to complete the Facilities, and (iii) an Officer's Certificate of such member of the Obligated Group stating that the proceeds of such Completion Indebtedness to be applied to the completion of the Facilities, together with a reasonable estimate of investment income to be earned on such proceeds and the amount of moneys, if any, committed to such completion by such Obligated Group member or through enumerated bank loans (including letters or lines of credit) or through federal or state grants, will be in an amount not less than the amount set forth in the statement of an architect or other expert referred to in (ii).

(c) Commitment Indebtedness of any member of the Obligated Group or any Guaranty of any Commitment Indebtedness of any member of the Obligated Group without limit.

(d) Long-Term Indebtedness of any member of the Obligated Group incurred for the purpose of refunding, repurchasing or refinancing (whether in advance or otherwise) any outstanding Long-Term Indebtedness; provided, however, that additional Long-Term Indebtedness permitted under this paragraph (d) shall not result in an increase in Maximum Annual Debt Service in excess of 10%.

(e) The conversion without limit of Long-Term Indebtedness of any member of the Obligated Group that is convertible from one interest or payment made to another interest or payment (e.g., weekly to monthly or to a fixed rate) from one mode to another pursuant to the terms of the documentation authorizing such Long-Term Indebtedness.

(f) Subordinated Indebtedness without limit of any member of the Obligated Group or Non-Recourse Indebtedness without limit of any member of the Obligated Group; provided, however, that in the case of Subordinated Indebtedness, the Obligated Group Agent shall have furnished the Master Trustee with a certificate showing that prior to the issuance of such Subordinated Indebtedness, the debt to capitalization ratio of the Obligated Group does not exceed 60%.

(g) Indebtedness incurred in connection with a sale of not more than 25% of accounts receivable with recourse by any member of the Obligated Group consisting of an obligation to repurchase all or a portion of such accounts receivable upon certain conditions, provided that the principal amount of such Indebtedness permitted shall not exceed the aggregate sales price of such accounts receivable received by such Obligated Group member.

(h) Long-Term Indebtedness of any member of the Obligated Group, the principal amount of which at the time incurred, together with the aggregate principal amount of all other Long-Term Indebtedness and Short-Term Indebtedness of the Obligated Group then outstanding, does not exceed 25% of the Total Net Operating Revenues for the most recent Fiscal year for which consolidated or combined financial statements reported upon by an independent certified public Accountant are available.

(i) Long-Term Indebtedness of any member of the Obligated Group if prior to the incurrence thereof an Officer's Certificate of the Obligated Group Agent is delivered to the Master Trustee certifying that, immediately following the incurrence of such Long-Term Indebtedness, the total outstanding Long-Term Indebtedness of the Obligated Group will not exceed 66-2/3% of the sum of the principal amount of all outstanding Long-Term Indebtedness of the Obligated Group, plus the equity accounts of the Obligated Group (i.e., unrestricted fund balances, including any shareholder equity or partnership equity).

Guaranties

Each Obligated Issuer agrees that it will not enter into, or become liable in respect of, or permit any Restricted Affiliate to enter into, or become liable in respect of, any Guaranty dated after the date of the Master Indenture unless the principal amount of the indebtedness being guaranteed could then be incurred as Indebtedness described under the heading "Additional Long-Term Indebtedness," taking into account the assumptions as to calculating the aggregate annual principal and interest payments on, and the principal amount of, the indebtedness being guaranteed, contained in the immediately succeeding paragraph.

In the case of Guaranties of indebtedness that would, if such indebtedness were incurred by a member of the Obligated Group, constitute Long-Term Indebtedness, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty shall be deemed to be equal to 20% of the principal and interest payments which would be payable on the indebtedness being guaranteed as if such indebtedness were Long-Term Indebtedness of the Guarantor. If at any time the Guaranty becomes due and payable, or if any payment has been made under the Guaranty during the two immediately preceding Fiscal Years, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty shall, for purposes of this paragraph, be deemed to equal 100% of the principal and interest payable on, and the principal amount of, the indebtedness being guaranteed for the Fiscal Year for which such determination is being made.

Debt Service on Balloon Indebtedness and Variable Rate Indebtedness

For purposes of the covenants and computations required or permitted pursuant to the Master Indenture, it shall be assumed that (A) the interest rate on Variable Rate Indebtedness is equal to the higher of (a) the current rate on the Variable Rate Indebtedness or (b) that rate that is the average of the rate of interest which was in effect on the last day of each of the twelve preceding full calendar months immediately preceding the month in which such calculation is made, provided that if the Variable Rate Indebtedness has not been outstanding for at least twelve full calendar months, the assumed rate of interest for such Variable Rate Indebtedness shall be the rate of interest borne on the date such Variable Rate Indebtedness was issued and (B) the principal of Balloon Indebtedness is amortized:

(i) from the date of calculation thereof over a term equal to twenty (20) years, with level annual debt service payments at an assumed interest rate equal to the Bond Index (provided if the Balloon Indebtedness is also Variable Rate Indebtedness, the assumed interest rate may, at the option of the Obligated Group Agent, be the assumed interest rate applicable to Variable Rate Indebtedness); or

(ii) during the term to the maturity thereof by deposits made to a sinking fund therefor pursuant to the terms of such Balloon Indebtedness or in accordance with a sinking fund schedule established by resolution of the Governing Body of the applicable Obligated Issuer adopted at or subsequent to the time of incurrence of such Balloon Indebtedness, as certified in an Officer's Certificate, provided that, at the time of such calculation, all deposits required to have been made prior to such date shall have been made; or

(iii) the principal of Balloon Indebtedness is due and payable on the specified due date or due dates thereof; or

(iv) with respect to Balloon Indebtedness for which there exists a Credit Facility, the principal of such Balloon Indebtedness is due and payable in the amounts and at the times specified in the Credit Facility or related documents.

Insurance

Each Obligated Issuer will maintain, or cause to be maintained, insurance covering such risks and in such amounts as, in its reasonable judgment, is adequate to protect it and its Property and operations, including (to the extent that such Obligated Issuer is a health care institution) professional liability or medical malpractice insurance, one year's business interruption insurance (if commercially available) and extended coverage property insurance in an amount sufficient to avoid co-insurance. The Master Trustee shall be named as an additional insured on all such insurance policies. The Obligated Group Agent shall retain an Insurance Consultant who will prepare and file with the Master Trustee a report showing the adequacy of such insurance once every two years (such report to be filed as soon as practicable but in no event later than five months after the end of the applicable second Fiscal Year). Each Obligated Issuer will follow any recommendations of the Insurance Consultant to the extent feasible in the opinion of the Obligated Group Agent.

In lieu of maintaining the insurance policies required above, the Obligated Group, or any member thereof, may self-insure any of the required coverages (or a portion thereof), provided that the Obligated Group may not self-insure any required coverage with respect to Property, Plant and Equipment and provided further that the Master Trustee receives a report (as soon as practicable but in no event later than five months after the end of each Fiscal Year) of an Insurance Consultant to the effect that such self-insurance is consistent with proper management and insurance practices. If any member of the Obligated Group elects to self-insure in lieu of maintaining medical liability and malpractice insurance, a report of an Insurance Consultant shall be filed with the Master Trustee annually stating that such Insurance Consultant has reviewed the self-insurance program and that the self-insured Obligated Group Member has available the estimated amount required for the payment of claims and associated claims expenses with respect to such Fiscal Year.

In the event of damage to or destruction of all or any part of the Facilities of the Obligated Group with a Value in excess of five percent (5%) of the Value of all Property of the Obligated Group, the affected Obligated Group member or the Obligated Group Agent shall exercise its best efforts to recover any applicable insurance. Such proceeds shall be paid to the Obligated Group Agent for the payment or reimbursement of reasonable expenses of obtaining the recovery. The Obligated Group Agent shall then give notice to the Master Trustee of such expenses and of the amount of the remaining proceeds (herein called the "Net Proceeds").

Subject to the provisions of any Related Financing Document pertaining to a Permitted Lien, the affected Obligated Group member shall apply the Net Proceeds for any lawful corporate purpose as such Obligated Group member determines, if the Obligated Group Agent shall first have delivered to the Master Trustee an Officer's Certificate stating that the Projected Debt Service Coverage Ratio for each of the next two full succeeding Fiscal Years immediately following the date of such certificate(s), taking into account such damage or destruction and the proposed use of the Net Proceeds is at least 1.10. If the Obligated Group Agent is unable to deliver the foregoing Officer's Certificate, the affected Obligated Group member shall apply the Net Proceeds or so much thereof as may be needed to the repair, replacement, restoration or reconstruction of the affected Facilities or, at the option of the applicable Obligated Group member, to any other capital project of equivalent value and utility, to the acquisition of any Property or to the repayment in whole or in part of any outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent shall determine.

Any Net Proceeds remaining after compliance by the affected Obligated Group member and the Obligated Group Agent with the immediately preceding paragraph shall be transferred by the Obligated Group Agent to the Master Trustee and applied to the redemption of the outstanding Obligations that directly finance the damaged or condemned facilities and are secured thereby, second to other direct outstanding Obligations of the affected Member of the Obligated Group, and third to the redemption of other outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent shall determine.

In the event of a taking by eminent domain of all or any part of the Facilities of the Obligated Group with a Value in excess of five percent (5%) of the Value of all Property of the Obligated Group, the affected Obligated Group member or the Obligated Group Agent shall exercise its best efforts to recover any applicable proceeds. Such proceeds shall be paid to the Obligated Group Agent. The Obligated Group Agent shall make appropriate deductions from such proceeds and give notice to the Master Trustee of such deductions and of the amount of the remaining proceeds (also, "Net Proceeds"). The Net Proceeds shall be applied in the same manner as insurance proceeds are applied pursuant to the two immediately preceding paragraphs.

Certain Covenants of the Obligated Issuers

Each Obligated Issuer covenants, among other things, to maintain its corporate or other separate legal existence and to be qualified to do business where such qualification is necessary, to maintain and keep its Facilities in good repair, to conduct its affairs in compliance with all applicable laws and regulations, to pay all lawful taxes and governmental charges and assessments levied or assessed upon or against it or its Property (except that each Obligated Issuer may withhold such payments where the validity of such taxes and assessments is being contested in good faith), to comply with any covenants and provisions of any Liens upon its property or securing any of its Indebtedness, to procure and maintain all necessary licenses and permits, to maintain accreditation of its health care Facilities and its status as a provider of health care services eligible for reimbursement under government programs (provided, however, that it need not comply with the requirements pertaining to licenses, permits, accreditation and its status as a provider if and to the extent its Governing Body shall have determined in good faith, evidenced by an Officer's Certificate that such compliance is not in its best interests and that lack of such compliance would not materially impair its ability to pay its indebtedness when due).

In addition, each Obligated Issuer covenants not to merge with or consolidate with any other person not a member of the Obligated Group or sell or convey all or substantially all of its assets to any person not a member of the Obligated Group unless: (a) the successor corporation (if other than the Obligated Issuer) shall be a person organized and existing under the laws of the United States of America or a state thereof and such person shall become an Obligated Issuer and shall expressly assume the due and punctual payment of the principal of, premium, if any, and interest on all outstanding Obligations according to their tenor, and the due and punctual performance and observance of all of the covenants and conditions of the Master Indenture by a Supplemental Indenture satisfactory to the Master Trustee, executed and delivered to the Master Trustee by such person; (b) if all amounts due or to become due on any outstanding Related Bonds which bear interest that is not includable in gross income under the Code have not been fully paid to the holders thereof (or provision for such payment has not been made in such manner as will result in the defeasance of the Related Financing Documents), the Master Trustee shall have received an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law the consummation of such merger, consolidation, sale or conveyance, whether or not contemplated on the date of the delivery of any such Related Bonds, would not cause the interest payable on such Related Bonds to become includable in gross income under the Code or adversely affect the validity of such Related Bonds; and (c) there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent to the effect that immediately following such transaction, (A) no Event of Default then exists nor, to such officer's knowledge, does there exist any event which, with the passage of time or the giving of notice or both, would or might become an Event of Default under the Master Indenture, and (B) either (1) if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the tests providing for the incurrence of Long-Term Indebtedness described in subsection (a)(i) or (ii) under the heading Additional Long-Term Indebtedness (assuming for purposes of such Certificate that the Income Available for Debt Service and Indebtedness of such person were Income Available for Debt Service and Indebtedness of an Obligated Issuer), or (2) such transaction will cure any Event of Default then in existence under the Master Indenture, or (3) by reason of such transaction, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such release will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such transaction not occurred, and (C) the combined fund balance and net worth, as the case may be, of the Obligated Group will not be less than 90% of such combined fund balance and net worth immediately prior to such transaction.

In case of any such consolidation, merger, sale or conveyance and upon any such assumption by the successor corporation, such successor corporation shall succeed to and be substituted for its predecessor.

In case of any such consolidation, merger, sale or conveyance, such changes in phraseology and form (but not in substance) may be made in Obligations thereafter to be issued as may be appropriate.

Permitted Encumbrances

No Obligated Issuer will create or suffer to be created or to exist (or permit any Restricted Affiliate to create or suffer to be created or to exist) any Lien upon any of their Property including, without limitation, all proceeds thereof, whether cash or non-cash, now owned or after acquired by any of them, other than Permitted Liens.

Disposition of Property

Each Obligated Issuer agrees that neither it will sell, lease or otherwise dispose of any Property, except for sales, leases or other dispositions of Property:

(a) To another member of the Obligated Group;

(b) To any person if prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate stating that, in the judgment of the officer executing such certificate, such Property has become, or within the next succeeding 24 calendar months is reasonably expected to become, inadequate, obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary and sale, lease, removal or other disposition thereof will not impair the structural soundness, efficiency or economic value of the remaining Property;

(c) To any person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent certifying (1) that Property transferred pursuant to this section in the then-current Fiscal Year by all Obligated Issuers does not exceed 5% of the Value of all Property of the Obligated Group for the immediately preceding Fiscal Year and (2) that Property transferred pursuant to this section in the then-current Fiscal Year and in each of the immediately preceding three Fiscal Years by all Obligated Issuers does not in the aggregate exceed 15% of the Value of all Property of the Obligated Group for the immediately preceding Fiscal Year;

(d) To any person provided that prior to the sale, lease or other disposition there is delivered to the Master Trustee an Officer's Certificate of the Obligated Group Agent, to the effect that immediately after the transfer in question, either (1) if one dollar of Additional Indebtedness were incurred, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to subsection (a)(i) or (ii) above contained under the heading Additional Long-Term Indebtedness or (2) such disposition will increase the Projected Debt Service Coverage Ratio in the Fiscal Year immediately following such disposition over what such ratio would have been in such Fiscal Year had such disposition not occurred;

(e) As part of a merger, consolidation, sale or conveyance permitted under the heading "Certain Covenants of the Obligated Issuers";

(f) In the ordinary course of business;

(g) To any person in connection with an operating lease of Property to such person;

(h) Upon fair and reasonable terms no less favorable than would be obtained in a comparable arm's-length transaction;

(i) To any person if the transfer involves any Property received as restricted gifts, grants, bequests or other similar sums or the income thereon, to the extent that such sums may not be pledged or applied to the payment of any Debt Service Requirement or operating expenses generally as a result of restrictions or designations imposed by the donor or maker of the gift, grant, bequest or other sums in question; or

(j) To any person so long as such Property is not encumbered by the Master Deed of Trust and the amount of Property transferred pursuant to this subsection (j) in any Fiscal Year shall not exceed $5,000,000.

To the extent that any Property of the Corporation that is permitted to be sold, leased or otherwise disposed of under the foregoing is encumbered by the Master Deed of Trust or the Master Indenture, upon receipt of an Officer's Certificate directing the Master Trustee to execute a release and/or termination statement with respect to such property to be sold, the Master Trustee shall execute and deliver to the Corporation a release and/or termination statement with respect to such property; provided, however, that no real property encumbered by the Master Deed of Trust shall be sold, leased or otherwise disposed of unless (1) such sale, lease or disposition is permitted under one of the provisions above and the Value of the Property being sold, leased or otherwise disposed of does not exceed $2,500,000 or (2) such Property is sold for fair market value (as determined by an appraisal delivered to the Master Trustee), provided that if such sale is of real property having an aggregate Book Value in excess of $15,000,000, the Corporation shall deliver to the Master Trustee an Officer's Certificate of the Obligated Group Agent to the effect that immediately after the transaction in question the Obligated Group (i) will have a Days Cash on Hand Ratio equal to or greater than 50 and (ii) will be in compliance with the provisions of the Master Indenture relating to rates and charges. In the event that any Property is released from the Master Deed of Trust pursuant to clause (2) of the immediately preceding sentence, the consideration received by the Corporation from the sale of such Property shall be applied to acquisition, construction or equipping of facilities for use by the Obligated Group or to the optional redemption or defeasance of outstanding Related Bonds, provided, however, that if outstanding Related Bonds are insured by the Bond Insurer at the time of such sale, the Bond Insurer shall be entitled to approve the application of any such consideration that is not used to redeem or defease Related Bonds and may in connection with any such approval required the Obligated Group to encumber additional real property pursuant to the Master Deed of Trust with a Value not less than the Value of the Property being released.

Filing of Financial Statements, Certificate of No Default, Other Information

The Obligated Group Agent covenants that it will:

(a) As soon as practicable but in no event later than four months after the end of each Fiscal Year, file, or cause to be filed, with the Master Trustee and, if such persons are then providing a rating with respect to Obligations or any Related Bonds, with each Rating Agency, (i) a combined or consolidated revenue and expense statement of the Corporation, and each other Obligated Issuer, for such Fiscal Year and (ii) a combined or consolidated balance sheet of the Corporation and each other Obligated Issuer as of the end of such Fiscal Year, each accompanied by the required report of an Accountant.

(b) As soon as practicable but in no event later than four months after the end of each Fiscal Year, file with the Master Trustee, an Officer’s Certificate of the Obligated Group Agent stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such Fiscal year, stating that all insurance required by the Master Indenture has been obtained and is in full force and effect, and stating whether or not to the best knowledge of the signers, any Obligated Issuer is in default in the performance of any covenant contained in the Master Indenture, and, if so, specifying each such default of which the signers may have knowledge, and an Officer’s Certificate stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such fiscal year, provided, if either such ratio is less than 1.75 to 1.00, such Officer’s Certificate shall be accompanied by a certificate of the accountant whose report accompanies the financial statements referred to in (a) above stating such ratios.

(c) If an Event of Default shall have occurred and be continuing, (i) file with the Master Trustee such other financial statements and information concerning its operations and financial affairs (or of any consolidated group of companies of which it is a member) as the Master Trustee may from time to time reasonably request, excluding specifically donor records, patient records and personnel records and (ii) provide access to its Facilities for the purpose of inspection by the Master Trustee during regular business hours or at such other times as the Master Trustee may reasonably request.

(d) Within 10 days after its receipt thereof, file with the Master Trustee a copy of each report which any provision of the Master Indenture requires to be prepared by a Consultant or an insurance consultant.

(e) As soon as practicable, but in no event later than 45 days after the end of each fiscal quarter, file, or cause to be filed, with the Master Trustee (i) a combined or consolidated revenue and expense statement of the Corporation and each other Obligated Issuer for such quarter, and (ii) a combined consolidated balance sheet presented on the basis described in (i) above as of the end of such quarter.

(f) Cause the information described in subsections (a), (b) and (e) above, including the calculations described in subsections (b) and (e) above, in each case any holder of $1,000,000 or more in aggregate principal amount of Related Bonds who has requested such of the Corporation in writing (it being understood that such request may be a standing request).

Rates and Charges

Each Obligated Issuer covenants and agrees to operate, and to cause each of its Restricted Affiliates to operate on a revenue producing basis and to charge, and to cause each of its Restricted Affiliates to charge, such fees and rates for its Facilities and services and to exercise, and to cause each of its Restricted Affiliates to exercise, such skill and diligence as to provide income from its Property together with other available funds sufficient to pay promptly all payments of principal and interest on its Indebtedness, all expenses of operation, maintenance and repair of its Property and all other payments required to be made by it under the Master Indenture to the extent permitted by law, and to use its best efforts to maintain in each Fiscal Year beginning with the Fiscal Year ending June 30, 2001 a ratio of Total Income Available For Debt Service to Maximum Annual Debt Service at least equal to 1.30. Each Obligated Issuer further covenants and agrees that it will from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of this Section.

If in any Fiscal Year beginning with the Fiscal Year ending June 30, 2001 the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.30, the Master Trustee shall require the Obligated Group, at the expense of the Obligated Group, to retain a Consultant to make recommendations with respect to the rates, fees and charges of the Obligated Group and its methods of operation and other factors affecting its financial condition in order to increase such Historical Maximum Annual Debt Service Coverage Ratio to at least 1.30.

A copy of the Consultant's report and recommendations, if any, and any written responses from management of the Corporation, shall be filed with each Obligated Issuer, the Master Trustee, each Related Bond Trustee and each Related Issuer and, upon written request to the Corporation, any holder of at least $1,000,000 in aggregate principal amount of Related Bonds. Each Obligated Issuer shall follow each recommendation of the Consultant applicable to it to the extent feasible (as determined by the Governing Body of such Obligated Issuer) and permitted by law. This Section shall not be construed to prohibit any Obligated Issuer from serving indigent patients to the extent required for such Obligated Issuer to continue its qualification as a Tax-Exempt Organization or from serving any other class or classes of patients without charge or at reduced rates so long as such service does not prevent the Obligated Group from satisfying the other requirements of this Section. So long as the Obligated Group shall retain a Consultant and shall follow such Consultant's recommendations to the extent permitted by law, this Section shall be deemed to have been complied with even if such ratio for any subsequent Fiscal Year is below 1.30:1; provided, however, that in no event shall the Historical Maximum Annual Debt Service Coverage Ratio for any year be less than 1.00:1.

Notwithstanding the provisions of the immediately preceding paragraph, if by the end of the second Fiscal Year after the Fiscal Year (beginning with the Fiscal Year ending June 30, 2001) for which the Obligated Group failed to achieve a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.30:1 the Obligated Group has not achieved a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.30:1, the Obligated Group shall be deemed to be in violation of the provisions of the Master Indenture.

The selection of any Consultant retained pursuant to this section and the scope of such Consultant's activities and recommendations shall be subject to the approval of the MBIA and ratification by each of the Holders of the two largest principal amounts of Uninsured Obligations; provided that the ratification by such Holders shall not be unreasonably withheld.

Liquidity Covenant

The Obligated Group shall maintain Unrestricted Liquid Funds as of the last day of each Fiscal Year to produce a Days Cash on Hand Ratio equal to or greater than 75 as of the last day of each Fiscal Year.

Accreditation

The Corporation shall not fail to maintain any accreditation status currently held by the Corporation with respect to its hospital facilities unless it provides the Master Trustee with a Consultant's opinion to the effect that failure to maintain any such accreditation will not adversely affect the Corporation's hospital facilities. Notwithstanding the foregoing, this Section shall not be construed to require the Corporation to continue to operate any hospital facility or to maintain any accreditation for any hospital facility that is closed.

Interest Rate Swap Obligations

The members of the Obligated Group may not enter into a Hedge Agreement without the prior written consent of the Bond Insurer (so long as any outstanding Related Bonds are insured by the Bond Insurer) unless the following conditions are met:

(a) The Hedge Agreement must be entered into as a hedge against (i) swaps currently outstanding (as in basis swaps or reverse swaps), or (ii) debt then outstanding or to be issued, or (iii) as a means of achieving forward transactions, or (iv) against assets held at the time of the execution of the Hedge Agreement;

(b) The Hedge Agreement does not contain any element of leverage or multiplier component in excess of 1.0x unless there is a matching hedge arrangement which effectively offsets the exposure from any such element or component;

(c) If an amount equal to the Maximum Adverse Termination Payment (as defined below) of all of the Hedge Agreements of the Obligated Group, then in effect and those to be executed, determined as noted in (i) and (ii) below, at the time the new Hedge Agreement is to be entered into were excluded from unrestricted cash and investments, the Days Cash on Hand Ratio would still be satisfied;

(i) The Obligated Group Agent shall calculate the Maximum Adverse Termination Amount in three steps. First, the Obligated Group Agent will determine the actual mark-to-market value of all existing Hedge Agreements of the Obligated Group using standard mark-to-market methodology. Second, the Obligated Group Agent will calculate the Adverse Termination Amount (as defined below) of the contemplated derivative based on (ii) below. Third, the Adverse Termination Amount of the contemplated Hedge Agreement will be added to the actual mark-to-market value of all existing Hedge Agreements.

(ii) The methodology for calculating the Adverse Termination Amount for the contemplated Hedge Agreement depends on the type of swap it is. If the contemplated swap is a floating-to-fixed interest rate swap, a fixed-to-floating interest rates swap, or an option to enter into or cancel either of those structures, the Obligated Group Agent will calculate the present value of a 150 basis point loss using standard mark-to-market methodology and will assume taxable and tax-exempt rates both shift 150 basis points on the day of the calculation. This will result in the Adverse Termination Amount for the new swap. If the contemplated swap is a basis swap, a fixed spread basis swap, a constant maturity swap, a spread swap, or a similar structure (with or without an option), the Obligated Group Agent will calculate a 50 basis point loss by multiplying the absolute present value of one basis point in the then current market by -50 (negative fifty), to reflect an adverse change in ratios, spreads, rates, and other market conditions. This will result in the Adverse Termination Amount for the new swap.

(d) The Obligated Group's counterparty (or its guarantor) shall be rated at least "A+" or "A1" by a Rating Agency at the time the Hedge Agreement is entered into and a Credit Support Annex shall, or is required to,

be executed to provide for collateral on a schedule that incorporates a zero threshold amount if any rating is below BBB+/Baa1;

(e) Termination payments are payable only if and to the extent that after such payment the Obligated Group: (a) would still be in compliance with its Days Cash on Hand Ratio, assuming such payment had been excluded from unrestricted cash and investments in making such liquidity calculation and (b) would not be in default;

(f) Collateral for the payments due under the Hedge Agreement can be posted only to the extent that after such posting the Obligated Group would still be in compliance with the Days Cash on Hand Ratio assuming such posting had been excluded from unrestricted cash and investments in making such liquidity calculation; and

(g) The uninsured payment due upon termination of any Hedge Agreement shall be subordinate in right of payment to all Obligations under the Master Indenture issued with respect to the Insured Bonds.

(h) The term "Adverse Termination Amount" shall mean the amount if positive that would be required to be paid by a member of the Obligated Group that is the party to a Hedge Agreement upon the termination of the Hedge Agreement calculated in the manner provided in subsection (c)(ii) above, and the term "Maximum Adverse Termination Amount" shall be determined in accordance with subsection (c)(i) above.

Projected Debt Service Coverage Ratio

Anything in the Master Indenture to the contrary notwithstanding, in each instance in the Master Indenture in which the Projected Debt Service Coverage Ratio is to be evidenced by an Officer's Certificate, such Projected Debt Service Coverage Ratio must also be evidenced by a Consultant's report unless the Projected Debt Service Coverage Ratio in such Officer's Certificate is greater than 1.75:1.00.

Defaults and Remedies

The following events are "Events of Default" under the Master Indenture:

(a) failure of any Obligated Issuer to make any payment of principal, redemption price or interest when due under the terms of any Obligations and such failure continues to exist as of the end of any applicable grace period; or

(b) failure of any Obligated Issuer to observe or perform any covenant or agreement contained in the Master Indenture or any Related Financing Documents for any Obligations for a period of 30 days after written notice of such failure, requiring the same to be remedied, has been given by the Master Trustee to each of the Obligated Issuers, the giving of which notice shall be at the discretion of the Master Trustee unless the Master Trustee is requested in writing to do so by the holders of at least 25% in aggregate principal amount of all outstanding Obligations, in which event such notice shall be given; provided, however, that if such observance or performance requires work to be done, actions to be taken, or conditions to be remedied, which by their nature cannot reasonably be don, taken or remedied, within such 30-day period, no Event of Default shall be deemed to have occurred or to exist if, and so long as, the defaulting Obligated Issuer shall commence such observance or performance within such 30-day period and shall diligently and continuously prosecute the same to completion; or

(c) (i) default of any Obligated Issuer in the payment of any Indebtedness (other than Obligations issued and outstanding under the Master Indenture), the principal amount of which in the aggregate exceeds 5% of the Book Value of all Property of the Obligated Group for the immediately preceding Fiscal Year, whether such Indebtedness now exists or shall be created after the date of the Master Indenture and any grace period with respect thereto shall have expired, or (ii) any event of default as defined in any Related Financing Documents under which any such Indebtedness may be issued, secured or evidenced shall occur, which default in payment or event of default results in such Indebtedness becoming or being declared due and payable unless within the time allowed for service of a responsive pleading in any proceeding to enforce payment of the Indebtedness under the laws governing such

proceeding (i) the Obligated Issuers commence proceedings to contest the existence or payment of such Indebtedness, and (ii) in the absence of such contest, neither the pledge and security interest created under the Master Indenture nor any Property of the Obligated Group will be materially impaired or subject to material loss or forfeiture; or

(d) bankruptcy, dissolution, liquidation or reorganization in bankruptcy of any Obligated Issuer or other similar events; or

(e) if the Hospital Maximum Annual Debt Service Coverage Ratio of the Obligated Group for any Fiscal Year is less than 1.0 to 1; or

(f) a breach of the Alliance's covenant to file audited financial statements as described above under "Filing of Financial Statements, Certificate of No Default, Other Information" under paragraph (a) thereof shall have occurred and be continuing; or

(g) a breach of the Alliance's "Liquidity Covenant" as described above shall have occurred and be continuing; or

(h) receipt by the Master Trustee of a written notice from the Bank issuing the Letter of Credit securing the 2011E Bonds of an event of default under the Reimbursement Agreement relating to such Bonds and a demand by such Bank for the acceleration of such Bonds.

Upon the occurrence of an Event of Default, the Master Trustee may, by notice in writing to the Obligated Issuers, declare the principal of all (but not less than all) outstanding Obligations to be immediately due and payable provided that the Master Trustee shall be required to make such a declaration (i) if an Event of Default has occurred under subsection (a) above, or (ii) if the Master Trustee is requested to make such a declaration by the Holders of not less than 25% in aggregate principal amount of all outstanding Obligations. If all Events of Default other than nonpayment of amounts that have become due as a result of such declaration are remedied, the Holders of 25% in aggregate principal amount of all Obligations may waive all Events of Default and rescind and annual such declaration of acceleration.

Any acceleration of the principal shall be subject to the condition that if, at any time after the principal of all outstanding Obligations shall have been accelerated, and before any judgment or decree for the payment of the moneys due shall have been obtained or entered: (i) one or more Obligated Issuers shall deposit with the Master Trustee an aggregate sum sufficient to pay (A) all matured installments of interest upon all outstanding Notes and the principal and premium, if any, of all outstanding Notes due otherwise than by acceleration (with interest on overdue installments of interest, to the extent permitted by law and on such principal and premium, if any, at the respective rates borne by such Notes to the date of such deposit) and any other amounts required to be paid pursuant to such Notes, (B) all amounts due under each Indenture Guaranty other than by reason of acceleration, (C) all sums due under any Obligations other than Notes and Indenture Guaranties, other than by reason of acceleration, and (D) the expenses and fees of the Master Trustee; and (ii) any and all Events of Default under the Master Indenture, other than the nonpayment of principal of and accrued interest on outstanding Obligations that have become due by acceleration, shall have been remedied, then and in every such case, the Master Trustee shall, if requested by the Holders of twenty-five percent in aggregate principal amount of all Obligations then outstanding, waive all Events of Default and rescind and annul such declaration and its consequences, but no such waiver or rescission and annulment shall extend to or effect any subsequent Event of Default.

The Master Trustee may, at any time that an Event of Default exists, (i) by written notice to the banking institutions in which any Gross Receipts are deposited pursuant to the requirements of the Master Indenture, direct that such funds be immediately transferred to the Master Trustee, and upon receipt of such funds the same shall be held in trust by the Master Trustee and disbursed as provided in the Master Indenture, and (ii) by written notice to the Obligated Issuers direct that all subsequent deposits of Gross Receipts be made with the Master Trustee.

Upon the occurrence of an Event of Default, as described in the Master Indenture, and upon demand of the Master Trustee, each Obligated Issuer will pay to the Master Trustee, for the benefit of the Holders of all

outstanding Obligations, (a) the amount then due and payable on all Obligations for principal or interest, or both, and such other amounts as may be required to be paid on all such Obligations, with interest on the overdue principal and installments of interest (to the extent permitted by law) at the respective rates of interest borne by such Obligations or as is provided in the applicable Supplemental Indenture, and (b) such further amounts sufficient to cover the cost and expenses of collection, including a reasonable compensation to the Master Trustee, its agents, attorneys and counsel, and any expenses incurred by the Master Trustee other than as a result of its gross negligence or bad faith.

The Master Trustee may institute any actions or proceedings at law or in equity for the collection of the sums due and may collect such sums in the manner provided by law out of the Property of the Obligated Issuer wherever situated.

In case there shall be pending proceedings for the bankruptcy or for the reorganization of any Obligated Issuer, or in case a receiver or trustee shall have been appointed for its Property, the Master Trustee shall be entitled and empowered, by intervention in such proceedings or otherwise, to file and prove a claim or claims for the whole amount of principal, premium, if any, interest and any other amounts owing and unpaid in respect of Obligations, and, in case of any judicial proceedings, to file such proofs of claim and other papers as may be necessary or advisable in order to have the claims of the Master Trustee and of the Holders of the Obligations allowed in such judicial proceedings relative to such member of the Obligated Group, its creditors or its Property, and to collect and receive any moneys or other Property payable or deliverable on any such claim and to distribute the same after the deduction of its charges and expenses.

All rights of action and rights to assert claims under any Obligation may be enforced by the Master Trustee without the possession of such Obligation. In any proceedings brought by the Master Trustee (and also any proceedings involving the interpretation of any provision of the Master Indenture to which the Master Trustee shall be a party) the Master Trustee shall be held to represent all the Holders of Obligations, and it shall not be necessary to make any Holders of Obligations parties to such proceedings.

Application of Moneys Collected

Any amounts collected by the Master Trustee in connection with the exercise of any rights and remedies following an Event of Default and, except as otherwise provided in the Master Indenture, all money and Investment Securities on deposit in any funds which the Master Trustee may establish under the Master Indenture from time to time shall be applied for the equal and ratable benefit of the Holders of Obligations in the following order at the date or dates fixed by the Master Trustee for the distribution of such moneys, upon presentment of such Obligations, and stamping thereon the payment, if only partially paid, and upon surrender thereof if fully paid:

(a) to the payment of costs and expenses of collection, including fees of Counsel and reasonable compensation to the Master Trustee; and, thereafter,

(b) whether or not the principal of all outstanding Obligations shall have become or have been declared due and payable to Holders of the outstanding Obligations for amounts due and unpaid on the Obligations, ratably, without preference or priority of any kind, according to the amounts due and payable on the Obligations; provided that for the purpose of determining the unpaid amount of any Obligation, there shall be deducted the amount, if any, which has been realized by the Holder by exercise of its rights as a secured party with respect to any Liens permitted pursuant to the Master Indenture or is on deposit in any fund established pursuant to any Related Financing Documents for such Obligations (other than amounts consisting of payments of principal and interest previously made and credited against the payments due under such Obligations) as of the date of payment by the Master Trustee pursuant to this subsection (b), all as certified to the Master Trustee by the Holder; and

(c) to the payment of the remainder, if any, to the Obligated Group Agent, its successors or assigns, or to whomsoever may be lawfully entitled to receive the same, or as a court of competent jurisdiction may direct.

All money drawn under the Letter of Credit securing the Series 2011E Bonds in connection with any Event of Default shall be applied only to the payment of principal and interest on the Series 2011E Bonds.

Actions by Holders

(a) No Holder of an Obligation shall have any right by virtue of or by availing of any provision of the Master Indenture to institute any suit, action or proceeding in equity or at law upon or under or with respect to the Master Indenture or for the appointment of a receiver or trustee, or any other remedy, unless the Holders of not less than 25% in aggregate principal amount of Obligations then outstanding shall have made written request upon the Master Trustee to institute such action, suit or proceeding in its own name as Master Trustee and shall have offered to the Master Trustee such reasonable indemnity as it may require against the costs, expenses and liabilities which may be incurred therein or thereby, and the Master Trustee, for 30 days after its receipt of such notice, request and offer of indemnity, shall have neglected or refused to institute any such action, suit or proceeding and no direction inconsistent with such written request shall have been given to the Master Trustee; it being understood and intended, and being expressly covenanted by the Holder of an Obligation and the Master Trustee, that no one or more Holders of Obligations shall have any right in any manner whatever by virtue of or by availing of any provision of the Master Indenture to affect, disturb or prejudice the rights of any other Holder of an Obligation or to obtain or seek to obtain priority over or preference to any other such Holder, or to enforce any right under the Master Indenture, except in the manner therein provided and for the equal, ratable and common benefit of all Holders of Obligations. For the protection and enforcement of these provisions, each and every Holder of an Obligation and the Master Trustee shall be entitled to such relief as can be given either at law or in equity.

(b) The Holder of an Obligation instituting a suit, action or proceeding in compliance with the provisions outlined herein and more fully set forth in the Master Indenture shall be entitled to such suit, action or proceeding to such amounts as shall be sufficient to cover the costs and expenses of collection, including to the extent permitted by applicable law, a reasonable compensation to its Counsel.

(c) Notwithstanding any other provision of the Master Indenture, the right of a Holder of an Obligation to receive payment of the principal of and interest on any Obligation and any other amounts payable thereunder, on or after the respective due dates expressed in such Obligation, or to institute suit for the enforcement of any such payment on or after such respective dates, shall not be impaired or affected without the consent of such Holder, provided that any moneys collected through the exercise of rights and remedies of any Holder against any Obligated Issuer pursuant to the Related Financing Documents for an Obligation (other than rights and remedies relating to Liens permitted pursuant to the Master Indenture or to funds and accounts established under such Related Financing Documents) shall be paid over to the Master Trustee or, with the consent of the Holder, collected directly by the Master Trustee.

Direction of Proceedings by Holders

The Holders of 75% in aggregate principal amount of Obligations then outstanding shall have the right to direct the time, method, and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred on the Master Trustee; provided, however, that, subject to its right to be indemnified in the Master Indenture, the Master Trustee shall have the right to decline to follow any such direction if the Master Trustee, being advised by Counsel, determines that the action so directed may not lawfully be taken, or if the Master Trustee in good faith shall, by a responsible officer or officers of the Master Trustee, determine that the proceedings so directed would be illegal or involve it in personal liability, and provided further that nothing in the Master Indenture shall impair the right of the Master Trustee in its direction to take any action deemed proper by the Master Trustee and which is not inconsistent with such direction by the Holders.

Delay or Omission of Master Trustee

No delay or omission of the Master Trustee, or of any Holder of an Obligation, to exercise any right or power accruing upon an Event of Default shall impair any such right or power, or be construed as a waiver of any Event of Default or an acquiescence therein, nor shall the action of the Master Trustee or of the Holders of Obligations in case of any Event of Default, or in case of any Event of Default and subsequent waiver of such Event of Default, affect or impair the rights of the Master Trustee or of such Holders in respect of any subsequent Event of Default or any right resulting therefrom.

Remedies Cumulative

No remedy under the Master Indenture is intended to be exclusive of any other remedy, but each and every other such remedy shall be cumulative, and shall be in addition to the remedies pursuant to the Master Indenture; and the employment of any remedy under the Master Indenture or otherwise, shall not prevent the concurrent employment of any such other appropriate remedy or remedies. In the pursuit of any such remedies, the Master Trustee shall have and be vested with the rights of a secured creditor under the Tennessee Uniform Commercial Code (or similar laws of other jurisdictions as applicable) with respect to moneys collected by the Master Trustee pursuant to any provision of the Master Indenture, and shall have the power to foreclose any Lien which may be granted to it as Master Trustee under the Master Indenture, all to the extent permitted by law.

Notice of Default

The Master Trustee shall, within 10 days after the occurrence of an Event of Default known to the Trustee, mail to all Holders of Obligations, as the names and addresses of such Holders appear upon the books maintained by the Master Trustee, and, as long as the Initial Obligation remains outstanding, to the MBIA, notice of such Event of Default under the Master Indenture known to the Master Trustee, unless such Event of Default shall have been cured before the giving of such notice; provided that, except above under "Defaults and Remedies," the Master Trustee shall be protected in withholding such notice if and so long as the Master Trustee in good faith determines that the withholding of such notice is in the interest of the Holders of the Obligations. For purposes of the Master Indenture, matters shall not be considered to be known to the Master Trustee unless an officer of its corporate trust department located at its principal corporate trust office has actual knowledge thereof.

Concerning the Master Trustee

Prior to the occurrence of an Event of Default and after the curing or waiving of all Events of Default which may have occurred, the Master Trustee undertakes to perform only those duties specifically set forth in the Master Indenture. In case an Event of Default has occurred, the Master Trustee shall exercise the rights and powers vested in it by the Master Indenture, and use the same degree of care and skill as a prudent man under the circumstances in the conduct of its own affairs.

No provision of the Master Indenture shall be construed to relieve the Master Trustee from liability for its own grossly negligent action, its own grossly negligent failure to act, or its own willful misconduct; provided, however, that:

(i) the Master Trustee shall not be liable for any error of judgment made in good faith by a responsible officer or officers of the Master Trustee, unless it is provided that the Master Trustee was grossly negligent in ascertaining the pertinent facts; and

(ii) the Master Trustee shall not be liable with respect to any action taken or admitted to be taken by it in good faith in accordance with the direction of the Holders of the majority in aggregate principal amount of Obligations then outstanding relating to the time, method and place of conducting any proceeding for any remedy available to the Master Trustee, or exercising any trust or power conferred upon the Master Trustee, under the Master Indenture.

Except as otherwise provided in the immediately preceding paragraph:

(a) The Master Trustee may rely and shall be protected in acting or refraining from acting upon various papers or documents believed by it to be genuine and to have been signed or presented by the proper party or parties.

(b) An Officer's Certificate (unless otherwise specifically prescribed) shall be sufficient evidence of any request, direction, order or demand of any Obligated Issuer mentioned under the Master Indenture. Any resolution of the Governing Body of an Obligated Issuer may be evidenced to the Master Trustee by copy thereof, certified by the Secretary or an Assistant Secretary of such Obligated Issuer.

(c) The Master Trustee may consult with Counsel, and the advice of such counsel shall be full and complete authorization and protection. The Master Trustee shall be relieved of liability to the Holders of the Obligations and to the Obligated Issuers in respect of any action taken, suffered or omitted by it under the Master Indenture in good faith and in accordance with Counsel's advice.

(d) Prior to the occurrence of an Event of Default under the Master Indenture and after the curing of all Events of Default, the Master Trustee is not bound to make any investigation into facts or matters stated in various papers or documents, unless requested in writing to do so by the Holders of a majority in aggregate principal amount of Obligations then outstanding. As a condition to proceeding with the requested investigation, the Master Trustee, in accordance with the terms of the Master Indenture, may require indemnity against various costs, expenses or liabilities.

(e) The Master Trustee may execute any of the trusts or powers under the Master Indenture or perform any duties under the Master Indenture either directly or by or through agents or attorneys.

(f) The Master Trustee shall be under no responsibility for the approval by it in good faith by an expert or other skilled person for any of the purposes expressed in the Master Indenture.

The recitals contained in the Master Indenture and in the Obligations (other than the Certificate of Authentication on such Obligations) shall be taken as the statements of the Obligated Issuer, and the Master Trustee assumes no responsibility for the correctness thereof. Further, the Master Trustee makes no representations as to the validity or sufficiency of the Master Indenture or the liens and security created thereunder or of the Obligations. The Master Trustee shall not be accountable for the use or application of: any of the Notes or the proceeds of such Obligations, any moneys paid over by the Master Trustee, or any moneys received by any paying agent other than the Master Trustee.

The Master Trustee, in its individual or any other capacity, may become the owner or pledgee of Obligations with the same rights it would have if it were not the Master Trustee under the Master Indenture. Further, the Master Indenture shall not prohibit the Master Trustee from serving as Trustee under any Related Financing Documents or for maintaining a banking relationship with any Obligated Issuer; provided that if the Master Trustee determines that there is a conflict with its duties under the Master Indenture, it shall eliminate the conflict or resign as Master Trustee.

Each Obligated Issuer shall pay, and shall be jointly and severally liable to pay, to the Master Trustee reasonable compensation, reimbursement for all reasonable expenses, disbursement and advances. Each Obligated Issuer shall indemnify, defend and shall be jointly and severally liable to indemnify, the Master Trustee and its officers, directors, employees and agents for, and to hold them harmless against, any loss, liability or expense incurred without gross negligence or willful misconduct on the part of the Master Trustee and arising out of or in connection with the acceptance or administration of such trusts, including the costs and expenses of defending itself against any claim of liability in the premises. The Obligated Issuers' joint and several obligations described in this paragraph shall survive the satisfaction and discharge of the Master Indenture and the resignation, removal and succession of the Master Trustee. Subject only to the rights of any Holder, the Master Trustee shall have an express first and prior lien on any moneys or Investment Securities on the deposit in any funds as security for the payment of all such obligations.

Subject to the first paragraph under this section entitled "Concerning the Master Trustee," any matter may be conclusively proved and established by an Officer's Certificate delivered to the Master Trustee. In the absence of bad faith on the part of the Master Trustee, any such Officer's Certificate shall be full ratification of any action taken, suffered or omitted by the Master Trustee under the provisions of the Master Indenture upon the faith thereof, and the Master Trustee shall not be obligated to make any investigation into the facts stated therein.

The Master Trustee may resign at any time without cause by giving notice as required under the Master Indenture. Further, the Master Trustee may be removed (a) with cause at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then outstanding, delivered to the Obligated Group and the Master Trustee, or (b) for any reason at the direction of the Obligation Group Agent if no Event of Default then exists under the Master Indenture. The Master Trustee shall promptly give notice of any removal pursuant to the

previous sentence in writing to each Holder of an Obligation then outstanding. In the case of the resignation and removal of the Master Trustee, a successor Master Trustee may be appointed by the Obligated Group unless an Event of Default exists under the Master Indenture. If an Event of Default exists under the Master Indenture, or if the Obligated Group otherwise fails to appoint a successor in accordance with the terms of the Master Indenture, a successor may be appointed at the direction of the Holders of not less than 66-2/3% in aggregate principal amount of Obligations then outstanding.

Any successor Master Trustee, however appointed, in accordance with the terms of the Master Indenture, shall accept such appointment, and, without further act, shall become vested with all the estates, properties, rights, powers and duties of its predecessor under the Master Indenture as if originally named the Master Trustee. The successor Master Trustee may, however, request that its predecessor execute and deliver an instrument transferring the above and assigning, transferring, delivering and paying over to such successor Master Trustee all moneys or other property then held by the predecessor under the Master Indenture.

Any successor Master Trustee, however appointed, shall be a bank or trust company having together with its Affiliates a combined capital and surplus on a consolidated basis of at least $50,000,000.

Any corporation into which the Master Trustee may be merged or converted or with which it may be consolidated, or any corporation resulting from any merger, conversion or consolidation to which the Master Trustee shall be a party, or any corporation to which substantially all the business of the Master Trustee may be transferred, shall, subject to the immediately preceding paragraph, be the Master Trustee under the Master Indenture without further act.

Subject to the terms and conditions as set forth in the Master Indenture, the Master Trustee shall have the power to appoint one or more persons not unsatisfactory to the Obligated Group Agent to act as Co-Master Trustee.

Modifications

Each Obligated Issuer, when authorized by a resolution of its Governing Body, and the Master Trustee may, without the consent of the holders of the Obligations then outstanding, enter into a Supplemental Indenture to the Master Indenture to (a) provide for the issuance of any Obligations under the Master Indenture, (b) evidence the addition of an Obligated Issuer or the succession of another corporation to any Obligated Issuer, (c) add additional covenants for the protection of the holders of Obligations, (d) cure any ambiguity or defective provision of the Master Indenture or any Supplemental Indenture in such manner as is not inconsistent with and does not impair the security of the Master Indenture or adversely affect the holders of Obligations of any series of Obligations issued under the Master Indenture, (e) qualify the Master Indenture under the Trust Indenture Act of 1939 or under any similar federal statute hereafter enacted, (f) provide for the establishment of additional funds and accounts, (g) permit the issuance of additional forms of Obligations provided such Obligations are equally and ratably secured with all other Obligations issued under the Master Indenture (except as provided herein), and (h) reflect a change in applicable law.

With the consent of the Holders of not less than a majority in aggregate principal amount of Obligations then outstanding, each Obligated Issuer, when authorized by its Governing Body, and the Master Trustee, may from time to time and at any time enter into a Supplemental Indenture for the purpose of adding any provisions to or changing in any manner or eliminating any of the provisions of the Master Indenture or of any Supplemental Indenture or of modifying in any manner the rights of the Holders of Obligations; provided, however, that (i) without the consent of the Holders of all Obligations whose Obligations are proposed to be modified, no such supplemental indenture shall effect a change in the times, amounts or currency of payment of the principal of, premium, if any, or interest on any Obligation or a reduction in the principal amount or redemption price of any Obligation or the rate of interest thereon or permit the preference or priority of any Obligation over any other Obligation; (ii) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall reduce the aforesaid percentage or affected class of Obligations, the Holders of which are required to consent to any such Supplemental Indenture; (iii) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall effect a change in the conditions for withdrawal as a Member of the Obligated Group; (iv) without the consent of the Holders of all Obligations then outstanding, no such supplemental indenture shall effect a change in the provisions permitting the Holders of 25% in aggregate principal

amount of all outstanding Obligations to direct acceleration upon the occurrence of an Event of Default; and (v) without the consent of the Holders of all Obligations then outstanding, any provision hereof which specifies a percentage of Holders required to take any action hereunder.

Effect of Supplemental Indenture

Upon the execution of any Supplemental Indenture, the Master Indenture shall be modified and amended in accordance therewith, and the respective rights, limitation of rights, obligations, duties, and immunities under the Master Indenture of the Master Trustee, each Obligated Issuer and the Holders of Obligations issued under the Master Indenture shall thereafter be determined, exercised and enforced under the Master Indenture subject in all respects to such modifications and amendments, and all the terms and conditions of any such Supplemental Indenture shall be deemed to be part of the terms and conditions of the Master Indenture.

Satisfaction and Discharge of Indenture

If the Master Trustee receives: (a) an amount which is (i) in the form of (A) cash, or (B) Government Obligations, and (ii) in a principal amount sufficient, together with the interest thereon and any funds on deposit under the Master Indenture and available for such purpose, to provide for the payment of the principal of and premium, if any, and interest on all outstanding Obligations to and including the maturity date or prior redemption or prepayment date thereof; (b) irrevocable instructions to redeem all Obligations to be redeemed prior to maturity and to notify the Holders of each such redemption; and (c) an amount sufficient to pay or provide for the payment of all other sums payable under the Master Indenture by the Obligated Issuers or any thereof, then the Master Indenture shall cease to be of further effect, and the Master Trustee, on demand of the Obligated Group Agent, shall execute all such instruments acknowledging satisfaction of and discharging the Master Indenture as requested by the Obligated Group Agent.

Similarly, the Obligated Issuer of any particular Obligation may provide for the payment thereof at or prior to maturity, and the Obligation so provided for shall thereupon cease to be outstanding under the Master Indenture.

In lieu of the foregoing, the Obligated Issuer of any particular Obligation may deliver to the Holder thereof the amount required under the Related Financing Documents to provide for the payment of the principal, premium, if any, and interest due or to become due in respect of such Obligation and such Obligation shall, upon surrender to the Master Trustee for cancellation, no longer be deemed outstanding under the Master Indenture.

SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE

Security and Pledge

The Bonds will be secured by the Issuer's grant and assignment under the Bond Indenture of (i) the Issuer's interest in the Series 2011 Obligation and the Loan Agreement, including but not limited to all revenues and receipts derived by the Issuer therefrom but excluding certain rights of the Issuer to (a) receive attorney fees under the terms of the Loan Agreement, (b) certain indemnification from the Alliance, (c) receive notices under the Loan Agreement, (d) to make advances under the Loan Agreement and (e) to inspect the projects financed with the Bonds, and (ii) all monies and securities in funds held by the Bond Trustee under the Bond Indenture (other than certain funds to be used to make rebate payments to the United States to preserve the tax-exempt status of the Bonds).

During the occurrence and continuation of an Event of Default under the Bond Indenture, the Bond Trustee will have a claim prior to the Bondholders on the moneys derived from the exercise of remedies under the Bond Indenture for payment of its costs and expenses and the repayment of advances made by it to effect performance of certain covenants in the Bond Indenture. The Bond Trustee, however, shall not have any claim or lien upon or with respect to moneys drawn under the Letter of Credit or the proceeds from the remarketing of Bonds.

Provisions for the Bonds

The Bond Indenture provides for the issuance of the Bonds, their redemption and all other terms pertaining to the Bonds. The Bonds will only be authenticated by the Bond Trustee upon the delivery of certain documents, including the original executed Bond Indenture, the Loan Agreement and the Original Letter of Credit.

Mutilated, lost or destroyed Bonds may be replaced subject to certain conditions specified in the Bond Indenture.

General Covenants and Provisions

The Issuer covenants that it will promptly pay the principal and purchase price of premium, if any, and interest on the Bonds subject to the limited nature of such obligations. The Issuer agrees that the Bond Trustee may enforce all rights of the Issuer under the Loan Agreement whether or not the Issuer is in default under the Bond Indenture.

Creation of Funds

The Bond Indenture provides for the creation of certain trust funds into which the proceeds from the sale of the Bonds, payments made by the Alliance under the Loan Agreement and proceeds from drawings on the Letter of Credit are to be deposited. These trust funds are the Bond Fund, the Construction Fund, the Bond Purchase Fund, and the Rebate Fund. Each of these funds is described below.

Bond Fund. Within the Bond Fund, the Bond Trustee is to create a General Account and a Letter of Credit Account. There is to be deposited in the General Account of the Bond Fund all payments made pursuant to the provisions of the Bond Indenture or the Loan Agreement for credit to the Bond Fund and all income derived from the investment of such amounts. The Bond Trustee will also establish a subaccount within the General Account in the Bond Fund for the purpose of holding all Eligible Moneys therein. Moneys held in the Eligible Money Subaccount of the Bond Fund shall not be commingled with any other funds or accounts. The Bond Trustee will credit to the Letter of Credit Account all moneys drawn by the Bond Trustee under the Letter of Credit to pay the principal of and interest on the Bonds and all income derived from the investment of such moneys. Moneys in the Letter of Credit Account shall not be commingled with any other funds or accounts. Moneys in the Bond Fund shall be used to pay principal, premium, if any, and interest on the Bonds and the redemption price of Bonds.

Project Fund. The moneys in the Project Fund shall be held in trust by the Bond Trustee, shall be applied to the payment of the costs of the projects being financed except to the extent required to be transferred to the Rebate Fund and, pending such application, shall be held as trust funds under the Bond Indenture in favor of holders of the outstanding bonds and for the further security of such holders until paid out or transferred as provided in the Bond Indenture.

Bond Purchase Fund. Within the Bond Purchase Fund, the Bond Trustee is to create a General Account and a Letter of Credit Account. There shall also be established a subaccount within the General Account for the purpose of holding Eligible Moneys therein. Moneys in the Bond Purchase Fund shall be used solely for the payment of the purchase price of the Bonds in the event of any purchase of Bonds at the option of the holder or on a Mandatory Tender Date. Payments received from the proceeds of the remarketing of the Bonds by the Remarketing Agent and all other moneys received by the Bond Trustee under the terms of the Bond Indenture or the Loan Agreement which are required to be deposited in the Bond Purchase Fund shall be credited to the General Account. All moneys drawn by the Bond Trustee under the Letter of Credit for the purchase of Bonds pursuant to the terms of the Bond Indenture and all income derived from the investment of such moneys shall be credited to the Letter of Credit Account. All moneys in the Bond Purchase Fund remaining on any Optional Tender Date or Mandatory Tender Date after payment of the purchase price of the Bonds purchased shall be paid to the Bank if the Bond Trustee receives prior notice from the Bank stating that certain specified amounts are due and payable to the Bank under the Reimbursement Agreement and any balance remaining after payment to the Bank shall be paid to the Alliance.

Rebate Fund. Any arbitrage profits to be rebated to the United States are to be held in the Rebate Fund. The Bond Indenture contains provisions regarding the responsibility of an independent rebate analyst to calculate the amount of such arbitrage profits.

Investment of Funds. Moneys (other than Eligible Moneys) held in the General Accounts of the Bond Fund and the Bond Purchase Fund (other than remarketing proceeds) and in the Construction Fund shall be invested by the Bond Trustee as directed by the Alliance in Investment Securities. Moneys held in the Letter of Credit Accounts of the Bond Fund and Bond Purchase Fund for more than two days and Eligible Moneys held in the General Accounts of the Bond Fund and the Bond Purchase Fund (other than remarketing proceeds) shall be invested by the Bond Trustee as directed by the Alliance in Government Obligations. Remarketing proceeds shall not be invested. The Bond Trustee shall sell and reduce to cash a sufficient amount of such investments whenever the cash balance in any fund or account is insufficient for the purposes thereof. The Bond Trustee shall not be responsible for any losses on investments made in accordance with the Bond Indenture. The Bond Trustee may make any investments through its own bond department or trust investments department.

Events of Default

The Bond Indenture provides that any of the following events shall constitute an Event of Default:

(a) default in the due and punctual payments of any interest on any Bond when the same shall become due and payable; or

(b) default in the due and punctual payment of the principal of any Bond at its maturity or upon mandatory redemption; or

(c) default in the due and punctual payment of the purchase price of Bonds required to be purchased pursuant to the Bond Indenture when payment of such amount has become due and payable; or

(d) receipt by the Bond Trustee of a written notice from the Bank of an event of default under the Reimbursement Agreement and a demand by the Bank for acceleration of the Bonds; or

(e) the occurrence of an "Event of Default" under the Loan Agreement.

Acceleration

Subject to the rights of the Bank to control remedies, upon the occurrence of any Event of Default described in paragraphs (a), (b), (c) or (f) above, the Bond Trustee may, and at the written request of the Bank or the holders of more than 50% in aggregate principal amount of the outstanding Bonds shall, and, upon the occurrence and continuance of an Event of Default described in paragraphs (d) or (e) above, the Bond Trustee shall, by notice in writing delivered to the Issuer, the Alliance and the Bank, declare the principal of all the Bonds immediately due and payable, whereupon the same shall become immediately due and payable, anything in the Bond Indenture or in the Bonds to the contrary notwithstanding. Upon any such acceleration, the Bonds and the interest thereon shall forthwith be paid in accordance with the Bond Indenture. Upon any declaration of acceleration under the Bond Indenture, the Bond Trustee shall immediately declare the payments required to be made by the Alliance under the Loan Agreement to be immediately due and payable in accordance with the Loan Agreement and, if during the Letter of Credit Period, shall draw on the Letter of Credit. Upon such a drawing on the Letter of Credit, the Bond Trustee shall immediately pay to the bondholders an amount equal to the principal of and accrued interest on the Bonds.

Other Remedies

Subject to the rights of the Bank to control remedies, upon the occurrence of an Event of Default under the Bond Indenture, the Bond Trustee shall have the power to proceed with any right or remedy available at law or in equity or by statute, as it may deem best, including any suit, action or special proceeding in equity or at law for the collection of amounts due and to become due under the Bond Indenture and under the Bonds or the performance of any covenant or agreement contained in the Bond Indenture or for the enforcement of any proper legal or equitable remedy as the Bond Trustee shall deem most effectual to protect the rights aforesaid, insofar as such may be authorized by law. The rights specified in the Bond Indenture are to be cumulative to all other available rights, remedies or powers.

No delay or omission to exercise any right or remedy accruing upon any Event of Default under the Bond Indenture shall impair any such right or remedy or shall be construed to be a waiver of any such Event of Default or acquiescence therein; and every such right and remedy may be exercised from time to time and as often as may be deemed expedient.

No waiver of any Event of Default under the Bond Indenture, whether by the Bond Trustee or by the bondholders, shall extend to or shall affect any subsequent event of default or shall impair any rights or remedies consequent thereon.

Rights of Bondholders

Upon the occurrence of an Event of Default and if requested to do so by more than two-thirds (2/3) in aggregate principal amount of Bonds then outstanding and being indemnified as provided in the Bond Indenture, the Bond Trustee subject to the provisions of the Bond Indenture, shall be obligated to exercise such one or more of the rights and remedies conferred heretofore as the Bond Trustee, being advised by counsel, shall deem most expedient in the interests of the bondholders and the Bank.

Right of Bondholders to Direct Proceedings

Except in the case of a default under paragraphs (d) and (e) under "Events of Default" and subject to the rights of the Bank to control remedies, the holders of more than two-thirds (2/3) in principal amount of Bonds then outstanding shall have the right, at any time, by an instrument or instruments in writing executed and delivered to the Bond Trustee, to direct the time, method and place of conducting all proceedings to be taken in connection with the enforcement of the terms and conditions of the Bond Indenture, or for the appointment of a receiver or any other proceedings under the Bond Indenture.

Application of Moneys

All moneys drawn by the Bond Trustee under the Letter of Credit in connection with any Event of Default shall be deposited in the Letter of Credit Account in the Bond Fund and all other moneys received by the Bond Trustee pursuant to any right given or remedy or action taken under the provisions of the Bond Indenture shall, after payment of all fees and expenses of the Bond Trustee, including, without limitation, the costs and expenses of the proceedings resulting in the collection of such other moneys and of the related expenses, liabilities and advances incurred or made by the Bond Trustee, be deposited in the General Account in the Bond Fund, and all such moneys shall be paid to the Bond Trustee and applied by it as follows:

(a) Unless the principal of all the Bonds shall have become or shall have been declared due and payable, all such moneys shall be applied:

> FIRST - to the payment to the persons entitled thereto of all installments of interest then due on the outstanding Bonds (other than Borrower Bonds and Pledged Bonds), in the order of the maturity of the installments of such interest and, if the amount available shall not be sufficient to pay in full any particular installment, then to the payment of such installment ratably, according to the amounts due on such installment, to the persons entitled thereto, without any discrimination or privilege;

SECOND - to the payment to the persons entitled thereto of the unpaid principal of any of the outstanding Bonds which shall have become due (other than Borrower Bonds and Pledged Bonds), in the order of their due dates, with interest on such Bonds at the rate last borne by the Bonds from the respective dates upon which they became due and, if the amount available shall not be sufficient to pay in full the principal which became due on such Bonds on any particular date, together with such interest, then to the payment thereof ratably, according to the amount of principal due on such date, to the persons entitled thereto, without any discrimination or privilege;

THIRD - to the payment of any amounts owed with respect to Pledged Bonds or owed by the Alliance to the Bank under the Reimbursement Agreement or other related documents or by the Issuer to the Bank under this Bond Indenture in such order as the Bank directs; and

FOURTH - to the payment of the principal of and interest on the Borrower Bonds in the same order of priority as specified in the first and second clauses.

(b) If the principal of all the Bonds shall have become due or shall have been declared due and payable, all such moneys shall be applied FIRST, to the payment of the principal and the interest then due and unpaid on the outstanding Bonds (other than Borrower Bonds and Pledged Bonds), without preference or priority of principal over interest or of interest over principal, or of any installment of interest over any other installment of interest, or of any such Bond over any other such Bond, ratably, according to the amounts due respectively for principal and interest, to the persons entitled thereto without any discrimination or privilege, SECOND, to the payment of any amounts owed with respect to Pledged Bonds or owed by the Alliance to the Bank under the Reimbursement Agreement or other related documents or by the Issuer to the Bank under this Bond Indenture in such order as the Bank directs and THIRD to the payment of the principal of and interest on the Borrower Bonds in the same manner as other outstanding Bonds.

(c) If the principal of all the Bonds shall have been declared due and payable, and if such declaration shall thereafter have been rescinded and annulled under the provisions of this Bond Indenture, in the event that the principal of all the Bonds shall later become due or be declared due and payable, the moneys to be applied shall be applied in accordance with the provisions of paragraph (b) above.

Subject to the provisions regarding acceleration, whenever moneys are to be applied pursuant to the provisions of this Section, such moneys shall be applied at such times, and from time to time, as the Bond Trustee shall determine, having due regard to the amount of such moneys available for application and the likelihood of additional moneys becoming available for such application in the future. Whenever the Bond Trustee shall apply such funds, it shall fix the date (which shall be an Interest Payment Date unless it shall deem another date more suitable or unless the principal of all of the Bonds has been declared immediately due and payable, in which case application shall be made immediately) upon which such application is to be made and upon such date interest on the amounts of principal to be paid on such dates shall cease to accrue provided that such amount of principal is in fact paid on such date. The Bond Trustee shall give such notice to the Holders of the Bonds and the Bank as it may deem appropriate of the deposit with it of any such moneys and of the fixing of any such date, and shall not be required to make payment from such moneys to the Holder of any Bonds until such Bond shall be presented to the Bond Trustee.

Rights and Remedies of Bondholders

No Holder of any Bond shall have any right to institute any suit, action or proceeding in equity or at law for the enforcement hereof, for the execution of any trust hereof or for the appointment of a receiver or to enforce any other right or remedy under the Bond Indenture, except subject to the rights of the Bank to control remedies and unless (a) a Default has occurred of which the Bond Trustee has been notified as provided in the Bond Indenture or of which it is deemed to have notice, (b) such Default shall have become an Event of Default and the Holders of more than two-thirds (2/3) in aggregate principal amount of Bonds then outstanding shall have made written request to the Bond Trustee and shall have offered reasonable opportunity to the Bond Trustee either to proceed to exercise the powers granted in the Bond Indenture or to institute such action, suit or proceeding in its own name, and (c) such Bondholders have offered to the Bond Trustee indemnity as provided in the Bond Indenture and the Bond Trustee shall thereafter fail or refuse to exercise the powers granted in the Bond Indenture, or to institute such action, suit or

proceeding in its own name. Such notification, request and offer of indemnity are at the option of the Bond Trustee conditions precedent to the execution of the powers and trusts hereof, and to any action or cause of action for the enforcement hereof, or for the appointment of a receiver or for any other right or remedy under the Bond Indenture. Nothing in the Bond Indenture shall, however, affect or impair the right of any Bondholder to enforce the payment of the principal and purchase price of, and interest on, any Bond at and after the date such payment is due, or the obligation of the Issuer or the Bond Trustee to pay the principal and purchase price of, and interest on, each of the Bonds to the respective Holders thereof at the time, place, from the source and in the manner expressed in the Bonds.

Waivers of Events of Default

Subject to the rights of the Bank to control remedies, the Bond Trustee shall waive any Event of Default under the Bond Indenture and its consequences upon the written request of the holders of more than 50% in aggregate principal amount of all Bonds then outstanding, provided, however, that there shall not be waived

(a) any Event of Default pertaining to the payment of the principal or purchase price of any Bond at its maturity, Redemption Date, or Tender Date, or

(b) any Event of Default pertaining to the payment when due of the interest on any Bond unless prior to such waiver, all arrears of interest and all principal or purchase price payments in respect of which such Event of Default shall have occurred, with interest thereon (to the extent permitted by law) for the period from the occurrence of such Event of Default until paid in full at a rate per annum equal to the interest rate payable on the Bonds from time to time during such period in accordance with the terms of the Bonds, and all expenses of the Bond Trustee in connection with such Event of Default, shall have been paid or provided for, and in case of any such waiver, or in case any proceeding taken by the Bond Trustee on account of any such Event of Default shall have been discontinued or abandoned or determined adversely to the Bond Trustee, then and in every such case the Issuer, the Bond Trustee, the Bank and the Bondholders shall be restored to their former positions and rights under the Bond Indenture, respectively, but no such waiver shall extend to any subsequent or other Event of Default, or impair any right consequent thereon, or

(c) any Event of Default described in paragraphs (d) or (e) under "Events of Default."

If a declaration of acceleration is made pursuant to the Bond Indenture, then and in every such case, the Bond Trustee shall upon the written request of more than two-thirds (2/3) in principal amount of all Bonds then outstanding rescind and annul such declaration, and the consequences thereof, provided that at the time such declaration is rescinded and annulled:

(1) no judgment or decree has been entered for the payment of any moneys due pursuant to the Bonds;

(2) all arrears of interest on all of the Bonds and all other sums payable under the Bonds (except as to principal of, and interest on, the Bonds which have become due and payable by reason of such declaration) shall have been duly paid;

(3) each and every Event of Default under the Bond Indenture shall have been waived pursuant to the preceding paragraph or otherwise made good or cured; and

(4) no drawing shall have been made under the Letter of Credit in connection with or as a result of such declaration of acceleration;

and, provided further, that no such rescission and annulment shall extend to or affect any subsequent Event of Default or impair any right consequent thereon. Notwithstanding the foregoing, neither the Bond Trustee nor the Bondholders shall have the right to waive an Event of Default described in paragraphs (d) or (e) under "Events of Default."

Rights of Bank to Control Remedies and Other Proceedings

Subject to the next paragraph, the Bank shall be entitled to control and direct the enforcement of all remedies and rights granted to the Holders of the Bonds and to the Bond Trustee under the Bond Indenture and all proceedings related thereto, including, without limitation,

(a) the right of the Holders of more than two-thirds (2/3) in aggregate principal amount of outstanding Bonds to request the acceleration of the principal of the Bonds;

(b) the right of the Holders of more than 50% in aggregate principal amount of outstanding Bonds to request the Bond Trustee to exercise certain remedies and direct the time, method and place of conducting all proceedings;

(c) the right to institute any suit, action or proceeding, pursuant to the Bond Indenture; and

(d) the right of the Holders of more than two-thirds (2/3) in aggregate principal amount of outstanding Bonds to waive any Event of Default or to rescind a declaration of acceleration of the principal of the Bonds;

provided that notwithstanding anything in the Bond Indenture to the contrary, the Bank may not direct the Bond Trustee not to accelerate the principal amount of the Bonds and draw on the Letter of Credit upon an Event of Default specified in paragraphs (a), (b) or (c) under "Events of Default."

All rights and remedies given to the Bank in the Bond Indenture and the Loan Agreement are expressly conditioned upon the Bank not being in default in the performance of its obligations under the Letter of Credit, and the Bank shall have no rights or remedies under the Bond Indenture or under the Loan Agreement if it is in default in such performance.

The Bond Trustee

After any Event of Default, the Bond Trustee shall exercise the rights and powers vested in it by the Bond Indenture with the degree of care and skill in their exercise as a prudent man would exercise in the conduct of his own affairs. Otherwise, the Bond Trustee undertakes to perform such duties and only such duties as are specifically set forth in the Bond Indenture, and no implied agreements or obligations shall be read into the Bond Indenture against the Bond Trustee. The Bond Trustee may execute its trusts through its employees, agents or attorneys, and the Bond Trustee shall not be responsible for any misconduct or negligence on the part of any agent or attorney appointed with due care by it. In carrying out its duties, the Bond Trustee may rely on any document believed by it to be genuine and to have been signed by the proper person and in determining the existence or nonexistence of any fact or the validity of any instrument, the Bond Trustee may rely on certificates provided by the Issuer or the Alliance.

The Bond Trustee is not required to take notice of any Event of Default under the Bond Indenture except failure by the Issuer to make payments on the Bonds, an Act of Bankruptcy of which it is given notice or Events of Default described in paragraphs (d) or (e) under "Events of Default." Before taking any action under the Bond Indenture or the Loan Agreement other than making a draw on the Letter of Credit, the Bond Trustee may require that a satisfactory indemnity bond be furnished. The Bond Trustee is not responsible for the tax-exempt status of the Bonds. The Bond Trustee is entitled to the payment of its reasonable fees and expenses.

The Bond Trustee may resign by giving written notice to the Issuer, the Alliance, the Bank and the Bondholders, provided that such resignation will not take effect until a successor trustee is appointed. The Bond Trustee may be removed at the written request of the holders of more than two-thirds (2/3) in the principal amount of the outstanding Bonds or by the Alliance (provided no Default or Event of Default has occurred under the Bond Indenture). The holders of more than two-thirds (2/3) in the principal amount of the outstanding Bonds may appoint a successor trustee.

The Bond Trustee will serve as Paying Agent under the Bond Indenture. The Paying Agent may resign by giving written notice to the Issuer, the Trustee, the Alliance, the Bank and the Bondholders, provided that such resignation will not take effect until a successor paying agent is appointed. The Paying Agent may be removed at the written request of the holders of more than [50%] in the principal amount of the outstanding Bonds or by the Alliance (provided no Default or Event of Default has occurred under the Bond Indenture). The holders of more than [50%] in the principal amount of the outstanding Bonds may appoint a successor paying agent.

The Remarketing Agent

The Remarketing Agent will set the interest rate on the Bonds, will remarket the Bonds upon purchase and will perform such other duties as are required under the Bond Indenture. The Remarketing Agent may resign by giving 30 days' notice to the Issuer, the Alliance, Bank and Bond Trustee provided that no such resignation shall take effect until a successor Remarketing Agent has been appointed. The Remarketing Agent may be removed from time to time by the Alliance.

Supplemental Bond Indentures

The Issuer and the Bond Trustee, without the consent of any of the bondholders may enter into an indenture or indentures supplemental to the Bond Indenture, as shall not be inconsistent with the terms and provisions thereof for any one or more of the following purposes: (a) to cure any ambiguity or formal defect or omission in the Bond Indenture or between the terms and provisions of the Bond Indenture and the terms and provisions of any other instrument or document executed in connection therewith or with the issuance of the Bonds; (b) to grant or confer upon the Bond Trustee for the benefit of the Bondholders any additional rights, remedies, power or authority; (c) to subject to the lien of the Bond Indenture additional payments, revenues or collateral; (d) to modify, amend or supplement the Bond Indenture or the bonds in such a manner as to permit qualification thereof under the Trust Indenture Act of 1939 or any federal or state securities law; (e) to evidence the appointment of a co-Bond Trustee or the succession of a new Bond Trustee; (f) to make any other supplement to the Bond Indenture which will not adversely affect the interest of the Bondholders; (g) to obtain or maintain a rating on the Bonds from S&P or Moody's as high as the debt rating of the Bank; (h) to modify or supplement the Bond Indenture in such manner as may be necessary, in the Opinion of Bond Counsel, to comply fully with all applicable rules, rulings, policies, procedures, regulations or other official statements promulgated or proposed by the Department of the Treasury or the Internal Revenue Service; or (i) as may be necessary in connection with the provision of a Substitute Letter of Credit meeting the requirements of the Bond Indenture.

Exclusive of supplemental indentures for the purposes described in the preceding paragraph and subject to the terms and provisions of the Bond Indenture, the holders of not less than two-thirds in aggregate principal amount of the bonds then outstanding shall have the right, from time to time, to consent to and approve the execution by the Issuer and the Bond Trustee of such other indenture or indentures supplemental to the Bond Indenture for the purpose of modifying, amending, adding to or rescinding, in any particular, any of the terms of provisions contained in the Bond Indenture; provided, however, that such modification or amendment shall not permit or be construed as permitting without the consent of the holders of all the Bonds outstanding (a) an extension of the maturity of the principal of, premium, if any, or interest on any of the Bonds, (b) a reduction in the principal amount of, premium, if any, or interest rate on, any Bond (c) a privilege or priority of any Bond or Bonds over any other Bond or Bonds, (d) a reduction in the aggregate principal amount of the bonds the holders of which are required to consent to any such supplemental indenture, (e) the creation of a lien ranking prior to or on a parity with the lien of the Bond Indenture on the property conveyed and mortgaged pursuant to the Bond Indenture or the deprivation of such lien or (f) the elimination of any mandatory redemption or mandatory purchase of Bonds, extension of the due date for the purchase of the Bonds or call for mandatory redemption or the reduction of the purchase price or Redemption Price for the Bonds.

Any supplemental indenture that affects the rights of the Alliance must be consented to by the Alliance. The Bond Trustee shall also not be required to enter into any supplemental indenture if such action might adversely affect its rights or liabilities. All supplemental indentures entered into during the Letter of Credit Period must be consented to by the Bank.

Amendments to the Loan Agreement

The Issuer may enter into, and the Bond Trustee may consent to, any amendment of or supplement to the Loan Agreement without notice to or consent of any Bondholder, if the amendment or supplement is required (a) by the provisions of the Loan Agreement or the Bond Indenture, (b) to cure any ambiguity, inconsistency or formal defect or omission in the Loan Agreement or between the terms and provisions of the Loan Agreement and the terms and provisions of any other instrument or document executed in connection therewith or with the issuance of the Bonds, (c) to identify more precisely any collateral securing the Bonds, (d) to effect any amendment that does not adversely affect the interests of the Bondholders or (e) to obtain or maintain a rating on the Bonds from S&P or Moody's as high as the debt rating on the Bank.

If an amendment of or supplement to the Loan Agreement without the consent of the Bondholders is not permitted as described in the foregoing paragraph, the Issuer may enter into, and the Bond Trustee may consent to, such amendment or supplement with notice to the Bondholders and with the consent of the holders of at least a two-thirds in principal amount of the Bonds then outstanding. However, no amendment to the Loan Agreement is permitted that would decrease the Trust's unconditional obligation to make payments under the Loan Agreement or that would affect the Trust's obligations as to the use of the proceeds of the Bonds. All amendments to the Loan Agreement entered into during the Letter of Credit Period must be consented to by the Bank.

SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT

Payments

The Alliance covenants to make all payments required by the Loan Agreement, as and when the same become due. Pursuant to the Loan Agreement, the Alliance agrees to make payments of principal, interest and purchase price identical to payments (including payments of principal upon redemption and acceleration) due by the Issuer under the Bonds. The obligations of the Alliance to make payments under the Loan Agreement shall be deemed satisfied to the extent of a corresponding payment made by the Bank to the Bond Trustee under the Letter of Credit. The Alliance also covenants to pay the reasonable fees and expenses of the Bond Trustee and the Issuer.

Special Representations and Covenants

Indemnification. The Alliance agrees that it will indemnify and save harmless the Issuer, City of Johnson, Tennessee, the Bond Trustee, the Remarketing Agent and the Bank from and against all liabilities, losses, expenses and damages arising generally from the operation of the projects financed with the Bonds or the failure of the Alliance to comply with its covenants or any term or condition contained in the Loan Agreement and any documents relating thereto.

Sale of Facilities. The Alliance may not sell, convey or lease the facilities financed or refinanced with the proceeds of the Bonds or any significant portion thereof unless the Alliance delivers to the Bond Trustee an Opinion of Bond Counsel that such sale, conveyance or lease will not adversely affect the exclusion from gross income of interest on the Bonds for federal income tax purposes. In connection with any such sale during the Letter of Credit Period, another party may assume the obligations of the Alliance under the Borrower Documents, and the Alliance may be released from liability therefrom with the written consent of the Bank.

Miscellaneous Covenants. The Alliance agrees to notify the Bank, the Issuer and the Bond Trustee if a petition in bankruptcy is filed against it.

Events of Default and Remedies on Default

The occurrence of any of the following events shall constitute an event of default under the Loan Agreement:

(a) If the Alliance shall fail to make any payment with respect to the principal and purchase price of or interest on the Bonds when the same becomes due and payable.

(b) If the Alliance shall fail to observe or perform any of its other covenants, conditions, or agreements under the Loan Agreement for a period of 30 days after notice (unless the Bank shall consent to an extension of such time), or in the case of any such default that cannot be cured within such 30-day period, if the Alliance shall fail to take corrective action to cure such default and diligently pursue such action until such failure is cured.

(c) If the Alliance shall (1) fail to pay generally its debts as they become due, (2) commence a voluntary case under the Federal bankruptcy laws, as now or hereafter constituted, or any other applicable Federal or state bankruptcy, insolvency or other similar law, (3) consent or fail to object to the appointment of a receiver, liquidator, assignee, trustee, custodian, sequestrator or other similar official for the Alliance or any substantial part of its property, or to the taking possession by any such official of any substantial part of the property of the Alliance, (4) make any assignment for the benefit of creditors, or (5) take corporate action in contemplation or in furtherance of any of the foregoing.

(d) If there shall occur the commencement of a voluntary or involuntary case by or against the Alliance under the Federal bankruptcy laws, as now or hereinafter constituted, provided, however, that if an involuntary case in bankruptcy is commenced against the Alliance prior to the 120th day before payment of the

Bonds (whether at maturity, by acceleration, demand for prepayment, call for redemption or otherwise), the filing of such petition shall not constitute an Event of Default if such petition is dismissed, subject to no further review, within 60 days thereafter.

(e) If any warranty, representation or other statement by or on behalf of the Alliance contained in the Loan Agreement or in any instrument furnished in connection with the issuance or sale of the Bonds shall prove to have been false or misleading in any material respect at the time it was made or delivered.

(f) If an Event of Default under the Bond Indenture shall occur and continue.

Upon an occurrence of an Event of Default, the Bond Trustee shall immediately notify the Bank and may:

(a) With the written consent of the Bank (provided such written consent shall not be required (1) if there is no Letter of Credit, or (2) if the Event of Default is due to the fact that there has been a default in the payment of the principal and purchase price or interest on the Bonds), declare all payments under the Loan Agreement and the Bonds to be immediately due and payable in an amount sufficient to pay all the principal of and premium, if any, and accrued interest on the Bonds, whereupon the same shall become immediately due and payable.

(b) Take whatever action at law or in equity may appear necessary or desirable to collect the amounts then due and thereafter to become due under the Loan Agreement or to enforce observance or performance of any covenant, condition or agreement of the Alliance.

Option to Prepay Obligations under Loan Agreement

The Alliance shall have the option to prepay its obligations under the Loan Agreement in whole or in part to the extent that the Bonds are redeemable under the provisions of the Bond Indenture. If the Alliance intends that such prepayment shall result in a redemption in whole or in part of the Bonds, the Alliance shall take such action as is required under the Bond Indenture to cause the Bonds to be redeemed. In the event the Alliance intends that such prepayment to cause the discharge of the lien of the Bond Indenture under the provisions thereof, the Alliance shall comply with such provisions.

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APPENDIX E

PROPOSED FORMS OF OPINIONS OF BOND COUNSEL

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[Opinion of Bass Berry Sims]

October 19, 2011

The Health and Educational Facilities Board
of the City of Johnson City, Tennessee
Johnson City, Tennessee

The Bank of New York Mellon Trust Company, N.A.,
Bond Trustee and Master Trustee
St. Louis, Missouri

U.S. Bank National Association
St. Louis, Missouri

PNC Bank, National Association
Pittsburgh, Pennsylvania

Merrill Lynch, Pierce, Fenner & Smith Incorporated
New York, New York

Re: The Health and Educational Facilities Board of the City of Johnson City, Tennessee $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A and $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B

Ladies and Gentlemen:

We have acted as bond counsel in connection with the issuance by The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer") of its $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011A (the "Series 2011A Bonds") and its $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011B (the "Series 2011B Bonds" and together with the Series 2011A Bonds, the "Series 2011 Bonds"). We have examined the law and such certified proceedings and other papers as we deem necessary to render this opinion. Reference is made to the forms of the Series 2011 Bonds for additional information concerning their details, payment and redemption provisions and the proceedings pursuant to which they were issued.

The Series 2011A Bonds are issued pursuant to a Bond Trust Indenture dated as of October 1, 2011 (the "Series 2011A Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2011A Bond Trustee"). The proceeds from the sale of the Series 2011A Bonds will be loaned by the Board to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of October 1, 2011 (the "Series 2011A Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the $_____ Mountain States Health Alliance Note, Series 2011A (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) (the "Series 2011A Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-First Supplemental Master Trust Indenture dated as of October 1, 2011 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2011A Loan Agreement and the Series 2011A Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2011A Bonds, and such payments and other revenues under the Series 2011A Loan Agreement and the Series 2011A Obligation (collectively, the "2011A Revenues") and the rights of the Issuer under the Series 2011A Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2011A Bonds.

U.S. Bank National Association, a national banking association (the "U.S. Bank"), has issued an irrevocable letter of credit dated the date hereof (the "2011A Letter of Credit") to secure payment of the principal of and up to 37 days' accrued interest on the Series 2011A Bonds which expires, unless extended, on _____.

The Series 2011A Bonds are payable solely from the 2011A Revenues and draws on the 2011A Letter of Credit.

The Series 2011B Bonds are issued pursuant to a Bond Trust Indenture, dated as of October 1, 2011 (the "Series 2011B Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2011B Bond Trustee"). The proceeds from the sale of the Series 2011B Bonds will be loaned by the Board to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of October 1, 2011 (the "Series 2011B Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the $_____ Mountain States Health Alliance Note, Series 2011B (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) (the "Series 2011B Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-First Supplemental Master Trust Indenture dated as of October 1, 2011 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2011B Loan Agreement and the Series 2011B Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2011B Bonds, and such payments and other revenues under the Series 2011B Loan Agreement and the Series 2011B Obligation (collectively, the "2011B Revenues") and the rights of the Issuer under the Series 2011B Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2011B Bonds.

PNC Bank, National Association, a national banking association (the "PNC"), has issued an irrevocable letter of credit dated the date hereof (the "2011B Letter of Credit") to secure payment of the principal of and up to 37 days' accrued interest on the Series 2011B Bonds which expires, unless extended, on _____.

The Series 2011B Bonds are payable solely from the 2011B Revenues and draws on the 2011B Letter of Credit.

Reference is made to an opinion of even date of Anderson, Fugate & Givens, counsel to the Alliance, with respect, among other matters, to the corporate status, good standing and qualification to do business of the Alliance, the corporate power of the Alliance to enter into and perform the Loan Agreements, the Series 2011 Obligations and the Master Indenture and the authorization, execution and delivery of the Loan Agreements, the Series 2011 Obligations and the Master Indenture by the Alliance and with respect to the Loan Agreements, the Series 2011 Obligations and the Master Indenture being binding and enforceable upon the Alliance.

As to questions of fact material to our opinion, we have relied upon representations of the Issuer and the Alliance contained in the Bond Indentures and the Loan Agreements, the certified proceedings and other certifications of public officials furnished to us, and certifications furnished to us by or on behalf of the Alliance (including certifications as to the use of bond proceeds and other bond issues which are material to paragraph 4 below), without undertaking to verify the same by independent investigation.

Based upon the foregoing, we are of the opinion that, under existing law:

1. The Issuer is duly created and validly existing as a public, nonprofit corporation, organized and existing under the laws of the State of Tennessee with the corporate power to enter into and perform the Bond Indenture and issue the Series 2011 Bonds.

2. Each Bond Indenture has been duly authorized, executed and delivered by the Issuer and is a valid and binding obligation of the Issuer enforceable against the Issuer. Each Bond Indenture creates a valid lien on the Revenues and on the rights of the Issuer under the corresponding Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) for the benefit of the corresponding Series 2011 Bonds.

3. The Series 2011 Bonds have been duly authorized, executed and delivered by the Issuer and are valid and binding special obligations of the Issuer, payable solely from the Revenues and draws on the applicable Letter of Credit.

4. Interest on the Series 2011 Bonds (a) will not be included in gross income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum income tax imposed on individuals and corporations; however, with respect to corporations (as defined for federal income tax purposes) such interest is taken into account in determining adjusted current earnings for purposes of computing the alternative minimum income tax on corporations. The foregoing opinion is given in reliance upon certifications by representatives of the Issuer and the Alliance as to certain facts relevant to both the opinion and the requirements of the Internal Revenue Code of 1986, as amended (the "Code"). The Issuer and/or the Alliance have covenanted to comply with the provisions of the Code regarding, among other matters, the use, expenditure and investment of the proceeds of the Series 2011 Bonds and the timely payment of arbitrage profits with respect to the Series 2011 Bonds to the United States. Failure by the Issuer or the Alliance to comply with such covenants could cause interest on the Series 2011 Bonds to be included in gross income for federal income tax purposes retroactively to their date of issue. We express no opinion regarding other federal tax consequences arising with respect to the Series 2011 Bonds.

5. The Series 2011 Bonds and the income therefrom shall be exempt from all state, county and municipal taxation in Tennessee except (a) inheritance, gift and estate taxes, (b) excise taxes on all or a portion of the interest on any of the Series 2011 Bonds during the period such Series 2011 Bonds are held or beneficially owned by any organization or entity, other than a sole proprietorship or general partnership, and (c) Tennessee franchise taxes by reason of the inclusion of the book value of the Series 2011 Bonds in the Tennessee franchise tax base of any organization or entity, other than a sole proprietorship or general partnership.

It is to be understood that the rights of the holders of the Series 2011 Bonds and the enforceability of the Series 2011 Bonds and each Bond Indenture may be subject to bankruptcy, insolvency, reorganization, moratorium and other laws affecting creditors' rights heretofore and hereafter enacted to the extent constitutionally applicable and that their enforcement may also be subject to the exercise of judicial discretion in appropriate cases.

Our services as bond counsel have been limited to rendering the foregoing opinion based on our review of such proceedings and documents as we deem necessary to approve the validity of the Series 2011 Bonds and the excludability of the interest on the Series 2011 Bonds from gross income for federal income tax purposes. We have not made any investigation concerning the financial resources of the Alliance and, therefore, we express no opinion as to the business or financial resources of the Alliance, its ability to provide for the payment of the Series 2011 Bonds or the accuracy or completeness of any information, including the Preliminary Official Statement dated _____ and the Official Statement dated _____, as both have been supplemented, that may have been relied on by anyone in making the decision to purchase the Series 2011 Bonds.

Very truly yours,

[Opinion of Bass Berry Sims]

October 19, 2011

Industrial Development Authority of Smyth County
Marion, Virginia

The Bank of New York Mellon Trust Company, N.A.,
Bond Trustee and Master Trustee
St. Louis, Missouri

U.S. Bank National Association
St. Louis, Missouri

Merrill Lynch, Pierce, Fenner & Smith Incorporated
New York, New York

Mizuho Corporate Bank, Ltd.,
New York Branch
New York, New York

Re: Industrial Development Authority of Smyth County $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C and $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D

Ladies and Gentlemen:

We have acted as bond counsel in connection with the issuance by Industrial Development Authority of Smyth County (the "Issuer") of its $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the "Series 2011C Bonds") and its $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the "Series 2011D Bonds" and together with the Series 2011C Bonds, the "Series 2011 Bonds"). We have examined the law and such certified proceedings and other papers as we deem necessary to render this opinion. Reference is made to the forms of the Series 2011 Bonds for additional information concerning their details, payment and redemption provisions and the proceedings pursuant to which they were issued.

The Series 2011C Bonds are issued pursuant to a Bond Trust Indenture dated as of October 1, 2011 (the "Series 2011C Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2011C Bond Trustee"). The proceeds from the sale of the Series 2011C Bonds will be loaned by the Board to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of October 1, 2011 (the "Series 2011C Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the $_____ Mountain States Health Alliance Note, Series 2011C (Industrial Development Authority of Smyth County) (the "Series 2011C Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-First Supplemental Master Trust Indenture dated as of October 1, 2011 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2011C Loan Agreement and the Series 2011C Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2011C Bonds, and such payments and other revenues under the Series 2011C Loan Agreement and the Series 2011C Obligation (collectively, the "2011C Revenues") and the rights of the Issuer under the Series 2011C Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2011C Bonds.

U.S. Bank National Association, a national banking association (the "U.S. Bank"), has issued an irrevocable letter of credit dated the date hereof (the "2011C Letter of Credit") to secure payment of the principal of

and up to 37 days' accrued interest on the Series 2011C Bonds which expires, unless extended, on _____.

The Series 2011C Bonds are payable solely from the 2011C Revenues and draws on the 2011C Letter of Credit.

The Series 2011D Bonds are issued pursuant to a Bond Trust Indenture, dated as of October 1, 2011 (the "Series 2011D Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Series 2011D Bond Trustee"). The proceeds from the sale of the Series 2011D Bonds will be loaned by the Board to Mountain States Health Alliance, a not-for-profit corporation incorporated under the laws of the State of Tennessee (the "Alliance"), under a Loan Agreement dated as of October 1, 2011 (the "Series 2011D Loan Agreement"), between the Issuer and the Alliance, which loan will be evidenced by the $_____ Mountain States Health Alliance Note, Series 2011D (Industrial Development Authority of Smyth County) (the "Series 2011D Obligation") issued pursuant to an Amended and Restated Master Trust Indenture dated as of February 1, 2000, as heretofore amended and as amended by a Thirty-First Supplemental Master Trust Indenture dated as of October 1, 2011 (collectively, the "Master Indenture"), between the Alliance and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Under the Series 2011D Loan Agreement and the Series 2011D Obligation, the Alliance has agreed to make payments to be used to pay when due the principal of and premium, if any, and interest on the Series 2011D Bonds, and such payments and other revenues under the Series 2011D Loan Agreement and the Series 2011D Obligation (collectively, the "2011D Revenues") and the rights of the Issuer under the Series 2011D Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) are pledged and assigned by the Issuer as security for the Series 2011D Bonds.

Mizuho Corporate Bank, Ltd., New York Branch (the "Mizuho"), has issued an irrevocable letter of credit dated the date hereof (the "2011D Letter of Credit") to secure payment of the principal of and up to 37 days' accrued interest on the Series 2011D Bonds which expires, unless extended, on _____.

The Series 2011D Bonds are payable solely from the 2011D Revenues and draws on the 2011D Letter of Credit.

Reference is made to an opinion of even date of Anderson, Fugate & Givens, counsel to the Alliance, with respect, among other matters, to the corporate status, good standing and qualification to do business of the Alliance, the corporate power of the Alliance to enter into and perform the Loan Agreements, the Series 2011 Obligations and the Master Indenture and the authorization, execution and delivery of the Loan Agreements, the Series 2011 Obligations and the Master Indenture by the Alliance and with respect to the Loan Agreements, the Series 2011 Obligations and the Master Indenture being binding and enforceable upon the Alliance.

As to questions of fact material to our opinion, we have relied upon representations of the Issuer and the Alliance contained in the Bond Indentures and the Loan Agreements, the certified proceedings and other certifications of public officials furnished to us, and certifications furnished to us by or on behalf of the Alliance (including certifications as to the use of bond proceeds and other bond issues which are material to paragraph 4 below), without undertaking to verify the same by independent investigation.

As to all matters of Virginia law, we have relied upon the attached opinion of Hunton & Williams LLP, Virginia bond counsel.

Based upon the foregoing, we are of the opinion that, under existing law:

1. The Issuer is duly created and validly existing as a public, nonprofit corporation, organized and existing under the laws of the State of Tennessee with the corporate power to enter into and perform the Bond Indenture and issue the Series 2011 Bonds.

2. Each Bond Indenture has been duly authorized, executed and delivered by the Issuer and is a valid and binding obligation of the Issuer enforceable against the Issuer. Each Bond Indenture creates a valid lien on the Revenues and on the rights of the Issuer under the corresponding Loan Agreement (except certain rights to indemnification, reimbursement and administrative fees) for the benefit of the corresponding Series 2011 Bonds.

3. The Series 2011 Bonds have been duly authorized, executed and delivered by the Issuer and are valid and binding special obligations of the Issuer, payable solely from the Revenues and draws on the applicable Letter of Credit.

4. Interest on the Series 2011 Bonds (a) will not be included in gross income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum income tax imposed on individuals and corporations; however, with respect to corporations (as defined for federal income tax purposes) such interest is taken into account in determining adjusted current earnings for purposes of computing the alternative minimum income tax on corporations. The foregoing opinion is given in reliance upon certifications by representatives of the Issuer and the Alliance as to certain facts relevant to both the opinion and the requirements of the Internal Revenue Code of 1986, as amended (the "Code"). The Issuer and/or the Alliance have covenanted to comply with the provisions of the Code regarding, among other matters, the use, expenditure and investment of the proceeds of the Series 2011 Bonds and the timely payment of arbitrage profits with respect to the Series 2011 Bonds to the United States. Failure by the Issuer or the Alliance to comply with such covenants could cause interest on the Series 2011 Bonds to be included in gross income for federal income tax purposes retroactively to their date of issue. We express no opinion regarding other federal tax consequences arising with respect to the Series 2011 Bonds.

5. Under current law, interest on the Series 2011 Bonds is exempt from income taxation by the Commonwealth of Virginia and any political subdivision thereof.

It is to be understood that the rights of the holders of the Series 2011 Bonds and the enforceability of the Series 2011 Bonds and each Bond Indenture may be subject to bankruptcy, insolvency, reorganization, moratorium and other laws affecting creditors' rights heretofore and hereafter enacted to the extent constitutionally applicable and that their enforcement may also be subject to the exercise of judicial discretion in appropriate cases.

Our services as bond counsel have been limited to rendering the foregoing opinion based on our review of such proceedings and documents as we deem necessary to approve the validity of the Series 2011 Bonds and the excludability of the interest on the Series 2011 Bonds from gross income for federal income tax purposes. We have not made any investigation concerning the financial resources of the Alliance and, therefore, we express no opinion as to the business or financial resources of the Alliance, its ability to provide for the payment of the Series 2011 Bonds or the accuracy or completeness of any information, including the Preliminary Official Statement dated _____ and the Official Statement dated _____, as both have been supplemented, that may have been relied on by anyone in making the decision to purchase the Series 2011 Bonds.

Very truly yours,

[*Opinion of Hunton & Williams LLP]*

October __, 2011

Industrial Development Authority of
Smyth County
Marion, Virginia

Bass, Berry & Sims PLC
Nashville, Tennessee

Industrial Development Authority of Smyth County
Hospital Revenue Bonds
(Mountain States Health Alliance)

Series 2011C	**Series 2011D**
$_____	**$_____**

Ladies and Gentlemen:

We have examined the applicable law, including the Industrial Development and Revenue Bond Act, Chapter 49, Title 15.2, Code of Virginia of 1950, as amended (the "Act"), and certified copies of proceedings and documents relating to the organization of the Industrial Development Authority of Smyth County (the "Authority") and the issuance and sale by the Authority of its $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C (the "Series 2011C Bonds"), and its $_____ Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D (the "Series 2011D Bonds" and, together with the Series 2011C Bonds, the "Bonds"). Reference is made to the form of the Bonds for additional information concerning their details, payment and redemption provisions and the proceedings pursuant to which they are issued. Terms used but not defined herein are defined in the Bond Indentures, as defined below.

The Series 2011C Bonds are issued pursuant to the provisions of a Bond Trust Indenture dated as of October 1, 2011 (the "Series 2011C Bond Indenture"), between the Authority and The Bank of New York Mellon Trust Company, N.A., as Bond Trustee (the "Bond Trustee"). The proceeds of the Series 2011C Bonds are being loaned by the Authority to Mountain States Health Alliance (the "Alliance"), Norton Community Hospital ("Norton") and Smyth County Community Hospital ("Smyth"), pursuant to a Loan Agreement dated as of October 1, 2011 (the "Series 2011C Loan Agreement").

The Series 2011D Bonds are issued pursuant to the provisions of a Bond Trust Indenture dated as of October 1, 2011 (the "Series 2011D Bond Indenture" and, together with the Series 2011C Bond Indenture, the "Bond Indentures"), between the Authority and the Bond Trustee. The proceeds of the Series 2011D Bonds are being loaned by the Authority to the Alliance, Johnston Memorial Hospital ("JMH") and Smyth pursuant to a Loan Agreement dated as of October 1, 2011 (the "Series 2011D Loan Agreement" and, together with the Series 2011C Loan Agreement, the "Loan Agreements"). Pursuant to the Loan Agreements, the Authority assigns to the Bond Trustee (a) as security for the Series 2011C Bonds, a $_____ promissory note of the Alliance dated October __, 2011 (the "Series 2011C Note"), (b) as security for the Series 2011D Bonds, a $_____ promissory note of the Alliance dated October __, 2011 (the "Series 2011D Note" and, together with the Series 2011C Note, the "Notes"), and (c) the Authority's rights (except for its rights to indemnification, payment of fees and expenses and receipt of certain notices).

The Notes state that they are issued pursuant to and governed by an Amended and Restated Master Trust Indenture dated as of February 1, 2000 (the "Master Indenture"), between the Alliance and The Bank of New York

Mellon Trust Company, N.A., as Master Trustee, as supplemented by a Thirty-First Supplemental Master Indenture dated as of October 1, 2011.

As further security for the Series 2011C Bonds, U.S. Bank National Association (the "Series 2011C Bank") has issued its irrevocable letter of credit (the "Series 2011C Letter of Credit") in an amount not to exceed $_____ authorizing the Bond Trustee to draw on the Series 2011C Bank, in accordance with the terms and conditions therein set forth, for payment of principal of, premium, if any, and up to 37 days' interest on the Series 2011C Bonds. Reference is also made to the opinion of Thompson Coburn LLP, counsel to the Series 2011C Bank, dated today, as to the validity and enforceability of the Series 2011C Letter of Credit against the Series 2011C Bank, upon which you are relying as to matters therein.

As further security for the Series 2011D Bonds, Mizuho Corporate Bank, Ltd. (the "Series 2011D Bank" and, together with the Series 2011C Bank, the "Banks") has issued its irrevocable letter of credit (the "Series 2011D Letter of Credit" and, together with the Series 2011C Letter of Credit, the "Letters of Credit") in an amount not to exceed $_____ authorizing the Bond Trustee to draw on the Series 2011D Bank, in accordance with the terms and conditions therein set forth, for payment of principal of, premium, if any, and up to 37 days' interest on the Series 2011D Bonds. Reference is also made to the opinion of Thompson Coburn LLP, counsel to the Series 2011D Bank, dated today, as to the validity and enforceability of the Series 2011D Letter of Credit against the Series 2011D Bank, upon which you are relying as to matters therein.

Without undertaking to verify the same by independent investigation, we have relied on certifications by representatives of the Alliance, Norton, Smyth, JMH, Smyth County, Virginia, and the Authority as to certain facts relevant to our opinion. We have not been requested to express, and therefore do not express, any opinion herein as to the treatment of interest on the Bonds under federal tax law, the necessity of registration of the Bonds under the Securities Act of 1933, as amended, or any state "Blue Sky" law, or any required qualification or registration under the Trust Indenture Act of 1939, as amended.

Based on the foregoing and assuming the due authorization, execution and delivery of all documents by parties other than the Authority, we are of the opinion that:

1. The Authority is duly organized and validly existing as an industrial development authority under the Act and has authority under the Act to issue and sell the Bonds.

2. The Bonds have been duly authorized and issued in accordance with the Act and constitute valid and binding limited obligations of the Authority, payable as to principal, premium, if any, and interest solely from the revenues and receipts derived from the Loan Agreements, including payments received under the Notes, and draws under the Letters of Credit. The Bonds do not create or constitute a debt or pledge of the faith and credit of the Commonwealth of Virginia or any political subdivision thereof, including the Authority and Smyth County, Virginia.

3. The Loan Agreements have been duly authorized, executed and delivered by the Authority, constitute valid and binding agreements of the Authority, and are enforceable against the Authority in accordance with their terms.

4. The Bond Indentures have been duly authorized, executed and delivered by the Authority, constitute valid and binding agreements of the Authority, assign and pledge to the Bond Trustee, as security for the Bonds, the Notes and all rights of the Authority under the Loan Agreements (except for its rights to indemnification, payment of fees and expenses and receipt of certain notices), and are enforceable against the Authority in accordance with their terms.

5. The rights of the holders of the Bonds and the enforceability of such rights, including enforcement by the Bond Trustee of the obligations of the Authority under the Loan Agreements and the Bond Indentures, may be limited or otherwise affected by (a) bankruptcy, insolvency, reorganization, moratorium, fraudulent conveyance and other laws affecting the rights of creditors generally, and (b) principles of equity, whether considered at law or in equity.

6. Under current law, interest on the Bonds is exempt from income taxation by the Commonwealth of Virginia and any political subdivision thereof.

Our services as bond counsel to the Authority have been limited to delivering the foregoing opinion based on our review of such proceedings and documents as we deem necessary to approve the validity of the Bonds. We express no opinion herein as to the financial resources of the Alliance and related entities, the Banks, their ability to provide for the payment of the Bonds or the accuracy or completeness of any information, including the Official Statement dated October __, 2011, that may have been relied on by anyone in making the decision to purchase the Bonds.

Very truly yours,

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APPENDIX F

PROPOSED FORM OF CONTINUING DISCLOSURE AGREEMENT

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CONTINUING DISCLOSURE AGREEMENT

This Continuing Disclosure Agreement (the "Agreement") is executed by the Mountain States Health Alliance, a Tennessee nonprofit corporation (the "Alliance), in connection with (i) the issuance by the Health and Educational Facilities Board of the City of Johnson City, Tennessee of its $65,260,000 Hospital Revenue Bonds (Mountain States Health Alliance) Series 2011A, and its $20,000,000 Hospital Revenue Bonds (Mountain States Health Alliance) Series 2011B, (ii) the issuance by the Industrial Development Authority of Smyth County of its $49,875,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011C and its $60,705,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2011D and (iii) the issuance by the Alliance of its $15,960,000 Taxable Bonds, Series 2011E (all such bonds, together the "Bonds").

1. Purpose of the Agreement

This Agreement is being executed and delivered by the Alliance for the benefit of the Beneficial Owners of the Bonds and in order to assist the Underwriter in complying with the Rule (as hereinafter defined).

2. Definitions

Except as otherwise indicated, any capitalized terms used, but not defined herein shall have the meaning assigned to them in the bond indenture pursuant to which the Bonds were issued. The following capitalized terms when used in this Agreement will have the following meanings:

"Annual Disclosure" means the annual financial information, audited financial statements prepared in accordance with generally accepted accounting principles and the operating data, all to be provided by the Alliance with respect to itself and any future Obligated Issuer pursuant to the Rule and this Agreement, as provided in Section 4 hereof.

"Beneficial Owner" means any person who (a) has the power, directly or indirectly, to vote or consent with respect to, or to dispose of ownership of, any Bonds (including persons holding Bonds through nominees, depositories or other intermediaries) or (b) is treated as the owner of any Bonds for federal income tax purposes.

"Listed Events" means any of the events listed below under "Reporting of Significant Events."

"MSRB" means the Municipal Securities Rulemaking Board, or any successor thereto. Currently, the MSRB's address is: MSRB, 1900 Duke Street, Suite 600, Alexandria, Virginia 22314, Attn: Disclosure.

"Official Statement" means the Official Statement, dated October 14, 2011, pursuant to which the Bonds were sold.

"Quarterly Disclosure" means the provision of the Quarterly Financial Information and any other financial information as provided in Section 5, hereof.

"Quarterly Financial Information" means (i) the Alliance's quarterly financial results in the form of its unaudited quarterly statement of excess of revenue over expenses and its unaudited quarterly balance sheet, each on a consolidated basis for the combined Obligated Group (as defined in the bond documents pursuant to which the Bonds are issued) and (ii) two calculations of the Historical Maximum Annual Debt Service Coverage Ratio (one utilizing a *pro forma* Total Income Available for Debt Service based upon the results of such quarter and the other utilizing Total Income Available for Debt Service over the rolling twelve month period ended with the end of such quarter).

"Rule" means Rule 15c2-12(b)(5) adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as previously amended and as the same may be amended from time to time.

"Underwriter" means Merrill Lynch & Co., as managing underwriter.

3. Provision of Annual Disclosure and Quarterly Disclosure

Not later than four months after the end of each fiscal year, the Alliance will file its Annual Disclosure with the MSRB. The Annual Disclosure may be submitted as a single document or as separate documents comprising a package, and may cross-reference other information as provided below.

Not later than 45 days after the end of each quarter of the Alliance's fiscal year the Alliance shall file its Quarterly Financial Information with the MSRB.

If the Annual Disclosure is not filed as provided in the preceding paragraph, the Alliance will send a notice to that effect to the MSRB.

4. Content of Annual Disclosure

The Alliance and any future Obligated Issuer shall provide and incorporate the following information in its Annual Disclosure:

(a) The audited financial statements of the Alliance and any future Obligated Issuer; and

(b) To the extent not included in the audited financial statements of the Alliance, the Alliance annually will make available the following financial and operating data:

(i) The patient origin analysis from all service areas as a percent of the discharges in Alliance-owned facilities for the prior 12 month period, as set forth under the caption "SERVICE AREA, MARKET SHARE AND COMPETITION – Patient Origin -- Alliance-Owned Facilities Patient Origin by Fiscal Year" in Appendix A of the Official Statement.

(ii) The percentage of gross patient revenues received by the Alliance from each program (i.e., Medicare, TennCare/Medicaid, Managed Care, Commercial and Other, and Private Pay) for the most recently concluded fiscal year, as set forth under the caption "SOURCES OF REVENUE – Gross Patient Revenues by Source of Payment (Payor Mix)" in Appendix A of the Official Statement.

(iii) The historic patient utilization for the Alliance and aggregate utilization for all divisions for the prior 12 month period ending June 30, as set forth under the caption "HISTORICAL UTILIZATION INFORMATION – Utilization by Fiscal Year" in Appendix A of the Official Statement.

Any or all of the items listed above may be incorporated by reference from other documents, including official statements of debt issues with respect to which the Alliance is an "obligated person" (as defined by the Rule), which have been filed in accordance with the Rule and the other rules of the Securities and Exchange Commission. If the document incorporated by reference is a final official statement, it must have been filed with and be available from the MSRB. The Alliance must clearly identify each such other document so incorporated by reference.

5. Content of Quarterly Disclosure

The Alliance's Quarterly Disclosure will contain its Quarterly Financial Information.

6. Reporting of Significant Events

The following are Listed Events:

(a) principal and interest payment delinquencies;

(b) non-payment related defaults, if material;

(c) unscheduled draws on debt service reserves reflecting financial difficulties;

(d) unscheduled draws on any credit enhancement reflecting financial difficulties;

(e) substitution of credit or liquidity providers, or their failure to perform;

(f) adverse tax opinions; the issuance by the IRS of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the Bonds, or other material events affecting the tax status of the Bonds;

(g) modifications of rights of the holders of the Bonds, if material;

(h) bond calls, if material, and tender offers;

(i) defeasance of all or any portion of the Bonds;

(j) release, substitution, or sale of property securing repayment of the Bonds, if material;

(k) rating changes;

(l) bankruptcy, insolvency, receivership or similar event of the Issuer;

(m) the consummation of a merger, consolidation, or acquisition involving the Issuer or the sale of all or substantially all of the assets of the Issuer, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and

(n) appointment of a successor or additional trustee or the change of name of a trustee, if material.

If the Alliance obtains knowledge of the occurrence of a Listed Event, the Alliance will, in a timely manner, file a notice of such occurrence with the MSRB. Notice of Listed Events described in subsections (h) and (i) will be disseminated automatically, but will not be given any earlier than the notice (if any) of the underlying event is given to the Beneficial Owners of affected Bonds pursuant to the governing bond documents. The content of any notice of the occurrence of a Listed Event will be determined by the Alliance.

7. Filing Method

Any filing required hereunder shall be made by transmitting such disclosure, notice or other information in electronic format to the MSRB through the MSRB's Electronic Municipal Market Access (EMMA) system pursuant to procedures promulgated by the MSRB.

8. Termination of Reporting Obligation

The Alliance's obligations under this Agreement will terminate upon the defeasance (within the meaning of the Rule), prior redemption or payment in full of all of the Bonds. The Alliance will notify the MSRB that the Alliance's obligations under this Agreement have terminated. If the Alliance's obligations are assumed in full by some other entity, such person will be responsible for compliance with this Agreement in the same manner as if it were the Alliance and the Alliance will have no further responsibility hereunder.

9. Dissemination Agent

The Alliance may, from time to time, appoint a dissemination agent to assist it in carrying out its obligations under this Agreement, and the Alliance may, from time to time, discharge the dissemination agent, with

or without appointing a successor dissemination agent. If at any time there is not a designated dissemination agent, the Alliance will be the dissemination agent.

10. Amendment

This Agreement may not be amended unless independent counsel experienced in securities law matters has rendered an opinion to the Alliance to the effect that the amendment does not violate the provisions of the Rule.

In the event that this Agreement is amended or any provision of this Agreement is waived, the notice of a Listed Event pursuant to subsection (6) under the heading "Reporting of Significant Events" will explain, in narrative form, the reasons for the amendment or waiver and the impact of the change in the type of operating data or financial information being provided in the Annual Disclosure. If an amendment or waiver is made in this Agreement which allows for a change in the accounting principles to be used in preparing financial statements, the Annual Disclosure for the year in which allows for a change in the accounting principles to be used in preparing financial statements, the Annual Disclosure for the year in which the change is made will present a comparison between the financial statements or information prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles. The comparison will include a qualitative discussion of the differences in the accounting principles and impact of the change in the accounting principles on the presentation of the financial information. A notice of the change in the accounting principles will be deemed to be material and will be filed with the MSRB.

11. Additional Information

Any registered owner of $1,000,000 or more in principal amount of Bonds shall receive, upon written request, any of the Annual Financial Information, Audited Financial Information or Quarterly Financial Information directly from the Alliance, by sending such request to Mountain States Health Alliance, 400 North State of Franklin Road, Johnson City, Tennessee 37604, Attn: Chief Financial Officer.

Nothing in this Agreement will be deemed to prevent the Alliance from disseminating any other information, using the means of dissemination set forth in this Agreement or any other means of communication, or including any other information in any Annual Disclosure or notice of occurrence of a Listed Event, in addition to that which is required by this Agreement. If the Alliance chooses to include any information in any Annual Disclosure or notice of occurrence of a Listed Event, in addition to that which is specifically required by this Agreement, the Alliance will have no obligation under this Agreement to update such information or include it any future Annual Disclosure or notice of occurrence of a Listed Event.

12. Default

In the event of a failure of the Alliance to comply with any provision of this Agreement, the Underwriter or any Beneficial Owner may take such actions as may be necessary and appropriate, including seeking specific performance by court order, to cause the Alliance to comply with its obligations under this Agreement. A default under this Agreement will not be deemed an Event of Default under the bond documents, and the sole remedy under this Agreement in the event of any failure of any party to comply with this Agreement will be an action to compel performance.

Acting by and through its duly authorized officer, the Alliance has caused this Continuing Disclosure Agreement to be executed under seal as of the 1st day of October, 2011.

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Its: Senior Vice President and
Chief Financial Officer

APPENDIX G

THE BANKS

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APPENDIX G-1

CERTAIN INFORMATION CONCERNING
MIZUHO CORPORATE BANK, LTD.

The delivery of this Appendix to the Official Statement shall not create any implication that there has been no change in the affairs of Mizuho since the date hereof, or that the information contained or referred to in this Appendix G-1 is correct as of any time subsequent to its date.

Mizuho Corporate Bank, Ltd. ("Mizuho") is a wholly-owned subsidiary of Mizuho Financial Group, Inc. ("MHFG"), a corporation organized under the laws of Japan.

MHFG is one of the largest financial institutions in the world, offering a broad range of financial services including banking, securities, trust and asset management, credit card, private banking, and venture capital through its group companies. MHFG's principal banking subsidiaries include Mizuho, Mizuho Bank, Ltd., and Mizuho Trust & Banking Co., Ltd. Mizuho was established on April 1, 2002, following a split and merger process of The Dai-Ichi Kangyo Bank, Limited, The Fuji Bank, Limited and The Industrial Bank of Japan, Limited.

Mizuho's New York branch (the "New York Branch") is licensed by the Banking Department of the State of New York as a branch to transact banking business in New York. The New York Branch is subject to supervision, examination and regulation by the New York State Banking Department and the Federal Reserve Board.

The long-term credit ratings of Mizuho by Moody's, Standard & Poor's and Fitch are A1, A+ and A, respectively, and the short-term credit ratings of Mizuho by Moody's, Standard & Poor's, and Fitch are P-1, A-1 and F 1, respectively.

A security rating is not a recommendation to buy, sell or hold securities and should be evaluated independently of any other rating. The rating is subject to revision or withdrawal at any time by the assigning rating organization.

Additional information, including the most recent annual report on Form 20-F for the fiscal year ended March 31, 2011, of MHFG, and additional annual, quarterly and current reports filed with or furnished to the Securities and Exchange Commission (the "SEC"), may be obtained without charge by each person to whom this Official Statement is delivered upon the written request of any such person to Mizuho Corporate Bank, Ltd., 1251 Avenue of the Americas, New York, New York 10020. This information is also available at www.mizuho-fg.co.jp/english/ and at the SEC's website at www.sec.gov.

THE MIZUHO LETTER OF CREDIT IS AN OBLIGATION OF MIZUHO AND IS NOT AN OBLIGATION OF MHFG. NO SUBSIDIARY OR AFFILIATE CONTROLLED BY MHFG, EXCEPT MIZUHO, IS OBLIGATED TO MAKE PAYMENTS UNDER THE MIZUHO LETTER OF CREDIT.

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August 10, 2011

PNC BANK, NATIONAL ASSOCIATION

This summary incorporates by reference certain Call Reports of PNC Bank, National Association ("PNC Bank"), filed with the Office of the Comptroller of the Currency ("OCC"), and certain reports of its parent, The PNC Financial Services Group, Inc. ("PNC Financial"), filed with the Securities and Exchange Commission ("SEC"), as set forth below under the heading "Incorporation of Certain Documents by Reference." You should read those reports and the information set forth below under the headings "PNC Bank and PNC Financial" and "Supervision and Regulation."

You should also understand that, except to the limited extent described herein, this summary does not describe the business or analyze the condition, financial or otherwise, of PNC Bank or otherwise describe any risks associated with PNC Bank or the Letter of Credit. You must rely on your own knowledge, investigation and examination of PNC Bank and PNC Bank's creditworthiness.

Neither PNC Bank nor PNC Financial makes any representation regarding the Bonds or the advisability of investing in the Bonds, nor do they make any representation regarding, nor has PNC Bank or PNC Financial participated in the preparation of, any document of which this summary is a part other than the information supplied by PNC Bank or PNC Financial and presented in this summary headed "PNC Bank, National Association."

THE LETTER OF CREDIT IS SOLELY AN OBLIGATION OF PNC BANK AND IS NEITHER AN OBLIGATION OF NOR GUARANTEED BY PNC FINANCIAL OR ANY OF ITS OTHER AFFILIATES.

PNC Bank and PNC Financial

PNC Bank is a national banking association with its headquarters in Pittsburgh, Pennsylvania and its main office in Wilmington, Delaware. PNC Bank is a wholly-owned indirect subsidiary of PNC Financial. PNC Bank's origins as a national bank date to 1865. PNC Bank and its subsidiaries offer a wide range of commercial banking, retail banking, and trust and wealth management services to their customers. PNC Bank's business is subject to examination and regulation by federal banking authorities. Its primary federal bank regulator is the OCC and its deposits are insured by the Federal Deposit Insurance Corporation ("FDIC").

PNC Financial, the parent company of PNC Bank, is one of the largest diversified financial services companies in the United States and is headquartered in Pittsburgh, Pennsylvania. PNC Financial was incorporated under the laws of the Commonwealth of Pennsylvania in 1983 with the consolidation of Pittsburgh National Corporation and Provident National Corporation. Since 1983, PNC Financial has diversified its geographic presence, business mix and product capabilities through internal growth, strategic bank and non-bank acquisitions and equity investments, and the formation of various non-banking subsidiaries.

PNC Financial has businesses engaged in retail banking, corporate and institutional banking, asset management, and residential mortgage banking. PNC Financial provides many of its products and services nationally and others in PNC Financial's primary geographic markets located in Pennsylvania, Ohio, New Jersey, Michigan, Maryland, Illinois, Indiana, Kentucky, Florida, Virginia, Missouri, Delaware, Washington, D.C., and Wisconsin. PNC Financial also provides certain products and services internationally.

On June 19, 2011, PNC Financial entered into a definitive agreement for PNC Financial to acquire RBC Bank (USA), the U.S. retail banking subsidiary of Royal Bank of Canada. Raleigh, N.C.-based RBC Bank (USA) has approximately $25 billion of assets and 424 branches in North Carolina, Florida, Alabama, Georgia, Virginia and South Carolina. Based on RBC Bank (USA) balances as of April 30, 2011, the acquisition would add approximately $19 billion of deposits and $16 billion of loans, net of agreed upon loan and deposit transfers. PNC Financial has also agreed to acquire certain credit card accounts of RBC Bank (USA) customers issued by RBC Bank (Georgia), National Association, a wholly-owned subsidiary of Royal Bank of Canada. The transaction is expected to close in March 2012, subject to customary closing conditions including regulatory approvals. Upon

closing, PNC Financial intends to merge RBC Bank (USA) into PNC Bank, with PNC Bank continuing as the surviving entity.

On July 26, 2011, PNC Financial entered into a definitive agreement for the acquisition of 27 branches in metropolitan Atlanta, Georgia from Flagstar Bank, FSB, a subsidiary of Flagstar Bancorp, Inc., and the assumption of approximately $240 million of deposits associated with those branches, based on balances as of June 30, 2011. No loans will be acquired in the transaction. This transaction is expected to close in December 2011, subject to customary closing conditions including regulatory approvals.

PNC Financial
in billions

	June 30, 2011	December 31, 2010
Total assets	$263.1	$264.3
Total deposits	$181.9	$183.4
Shareholders' equity	$32.2	$30.2

PNC Bank
in billions

	June 30, 2011	December 31, 2010
Total assets	$254.8	$256.6
Total loans (net of unearned income) and loans held for sale	$153.2	$154.2
Total deposits	$188.1	$191.9
Total equity capital	$35.2	$33.8

Supervision and Regulation

PNC Financial, the parent company of PNC Bank, is a bank and financial holding company and is subject to numerous governmental regulations involving both its business and organization. To a substantial extent, the purpose of the regulation and supervision of financial services institutions and their holding companies is not to protect shareholders and non-customer creditors, but rather to protect customers and the financial markets in general.

Applicable laws and regulations restrict permissible activities and investments and require compliance with protections for loan, deposit, brokerage, fiduciary, mutual fund and other customers, among other things. They also restrict PNC Financial's ability to repurchase its stock or to receive dividends from its subsidiaries that operate in the banking and securities businesses and impose capital adequacy requirements. The consequences of noncompliance can include substantial monetary and nonmonetary sanctions. In addition, PNC Financial and PNC Bank are subject to comprehensive examination and supervision by banking and other regulatory bodies. Examination reports and ratings (which often are not publicly available) and other aspects of this supervisory framework could materially impact the conduct, growth, and profitability of the company's operations.

There have been numerous legislative and regulatory developments and dramatic changes in the competitive landscape of the financial services industry over the last several years. The United States and other governments have undertaken major reform of the regulatory oversight structure of the financial services industry, including engaging in new efforts to impose requirements designed to protect consumers and investors from financial abuse. PNC Financial expects to face further increased regulation of the financial services industry as a result of current and future initiatives intended to provide economic stimulus, financial market stability, and enhanced regulation of financial services companies and to enhance the liquidity and solvency of financial institutions and markets. PNC Financial and PNC Bank also expect in many cases more intense scrutiny from bank supervisors in the examination process and more aggressive enforcement of regulations on both the federal and state levels. Compliance with regulations and other supervisory initiatives will likely increase the company's costs and reduce its revenue, and may limit its ability to pursue certain desirable business opportunities.

The Dodd-Frank Wall Street Reform and Consumer Protection Act ("Dodd-Frank") mandates the most wide-ranging overhaul of financial industry regulation in decades. Dodd-Frank was signed into law on July 21, 2010. Although Dodd-Frank and other reforms will affect a number of the areas in which PNC Financial does business, it is not clear at this time the full extent of the adjustments that will be required and the extent to which PNC Financial will be able to adjust its businesses in response to the requirements. Many parts of the law are now in effect and others are now in the implementation stage, which is likely to continue for several years. The law requires that regulators, some of which are new regulatory bodies created by Dodd-Frank, draft, review and approve more than 300 implementing regulations and conduct numerous studies that are likely to lead to more regulations, a process that, while well underway, is proceeding somewhat slower than originally anticipated, thus extending the uncertainty surrounding the ultimate impact of Dodd-Frank on PNC Financial and its subsidiaries.

A number of reform provisions are likely to significantly impact the ways in which bank holding companies and banks, including PNC Financial and PNC Bank, do business. Additional information regarding a number of these provisions (including new consumer protection regulation, enhanced capital requirements, limitations on investment in and sponsorship of funds, risk retention by securitization participants, new regulation of derivatives, potential applicability of state consumer protection laws, and limitations on interchange fees) and some of their potential impacts on PNC Financial is provided in Item 1A Risk Factors included in Part II of PNC Financial's second quarter 2011 Quarterly Report on Form 10-Q.

You will find a general discussion of some of the elements of the regulatory framework affecting PNC Financial and its subsidiaries, additional information discussing the regulatory environment for the financial services industry, and discussion of certain business and regulatory risks that affect PNC Financial in the following sections of PNC Financial's 2010 Annual Report on Form 10-K and its 2011 Quarterly Reports on Form 10-Q, as applicable: for the 2010 Form 10-K, the Supervision And Regulation section included in Item 1 – Business, Item 1A – Risk Factors, and Note 21 Regulatory Matters, Note 22 Legal Proceedings, and Note 23 Commitments and Guarantees of the Notes To Consolidated Financial Statements included in Item 8 of that report; and for the 2011 Form 10-Qs, Item 1A – Risk Factors included in Part II, and the Legal Proceedings and Commitments and Guarantees Notes of the Notes To Consolidated Financial Statements included in Part I, of those respective reports as applicable.

Incorporation of Certain Documents by Reference

PNC Bank submits certain unaudited reports called "Consolidated Reports of Condition and Income" ("Call Reports") to the OCC, its primary federal bank regulator, quarterly. Each Call Report consists of a balance sheet, income statement, changes in bank equity capital, and other supporting schedules as of the end of or for the period to which the report relates. The Call Reports are prepared in accordance with regulatory instructions issued by the Federal Financial Institutions Examination Council. Because of the special supervisory, regulatory and economic policy needs served by the Call Reports, those regulatory instructions do not in all cases follow accounting principles generally accepted in the United States, including the opinions and statements of the Accounting Principles Board or the Financial Accounting Standards Board ("U.S. GAAP"). While the Call Reports are supervisory and regulatory documents, not primarily financial accounting documents, and do not provide a complete range of financial disclosure about PNC Bank, the reports nevertheless provide important information concerning the financial condition and results of operations of PNC Bank.

The publicly available portions of the Call Reports are on file with, and publicly available on written request to, the FDIC, Public Information Center, 3501 North Fairfax Drive, Arlington, VA 22226, or by calling the FDIC Public Information Center at 877-275-3342 or 703-562-2200. The Call Reports are also available by accessing the FDIC's website at http://www.fdic.gov.

PNC Financial, the parent company of PNC Bank, is subject to the informational requirements of the Securities Exchange Act of 1934 ("Exchange Act"). In accordance with the Exchange Act, PNC Financial files annual, quarterly and current reports, proxy statements, and other information with the SEC. PNC Financial's SEC File Number is 001-09718. You may read and copy this information at the SEC's Public Reference Room, located at 100 F Street, N.E., Room 1580, Washington, D.C. 20549. You can obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330 or 202-551-8090. You can also obtain copies of this information by mail from the public reference section of the SEC, 100 F Street, N.E., Washington, D.C. 20549, at prescribed rates.

The SEC also maintains an internet site that contains reports, proxy and information statements, and other information regarding issuers, like PNC Financial, who file electronically with the SEC. The address of that website is http://www.sec.gov. You can also inspect reports, proxy statements and other information about PNC Financial at the offices of the New York Stock Exchange, Inc., 20 Broad Street, New York, New York 10005.

We have included the web addresses of the FDIC and the SEC as inactive textual references only. Except as specifically incorporated by reference into this summary, information on those websites is not part hereof.

The publicly-available portions of PNC Bank's Call Reports for the years ended December 31, 2010, 2009, and 2008 and for the quarters ended March 31, 2011 and June 30, 2011, and of any amendments or supplements thereto, as filed by PNC Bank with the OCC, are incorporated herein by reference. The publicly-available portions of each other PNC Bank Call Report, and of any amendments or supplements thereto or to any of the PNC Bank Call Reports listed above, filed with the OCC after December 31, 2010 and prior to the expiration of the Letter of Credit are also incorporated herein by reference and will be deemed a part hereof from the date of filing of each such document. Subsequently filed reports, and amendments or supplements to reports, will automatically update and supersede prior information.

In addition to the Call Reports referred to above, PNC Bank incorporates herein by reference the following documents: PNC Financial's Annual Report on Form 10-K for the year ended December 31, 2010; PNC Financial's Quarterly Reports on Form 10-Q for the quarters ended March 31, 2011 and June 30, 2011; PNC Financial's Current Reports on Form 8-K filed with the SEC on February 15, 2011, March 1, 2011, March 7, 2011, April 14, 2011, May 2, 2011, June 20, 2011 (with respect to Item 1.01 and Exhibit 2.1 thereof), and July 27, 2011; and any amendments or supplements to those reports. Each other annual, quarterly and current report, and any amendments or supplements thereto or to any of the PNC Financial reports listed above, filed by PNC Financial with the SEC pursuant to Section 13(a) or 15(d) of the Exchange Act after December 31, 2010 and prior to the expiration of the Letter of Credit is also incorporated herein by reference and will be deemed a part hereof from the date of filing of each such document. Subsequently filed reports, and amendments or supplements to reports, will automatically update and supersede prior information. The information incorporated by reference herein does not include any report, document or portion thereof that PNC Financial furnishes to, but does not file with, the SEC unless otherwise specifically provided above.

Neither the delivery of this document nor the sale of any Bonds will imply that the information herein or in any document incorporated by reference is correct as of any time after its date. Any statement contained in a document incorporated or deemed to be incorporated by reference herein will be deemed to be modified or superseded for purposes hereof to the extent that a statement contained therein or in any other subsequently filed document which also is or is deemed to be incorporated by reference herein modifies or supersedes such statement. Any statement so modified or superseded will not be deemed, except as so modified or superseded, to constitute a part hereof.

Any of the above documents incorporated herein by reference (other than exhibits to such documents unless such exhibits are specifically incorporated by reference into such documents) are available upon request by holders of the Bonds or by prospective investors in the Bonds without charge: (1) in the case of PNC Bank documents, by written request addressed to Ronald Lewis, Manager of Regulatory Reporting, at The PNC Financial Services Group, Inc., One PNC Plaza, 249 Fifth Avenue, Pittsburgh, Pennsylvania 15222-2707; or (2) in the case of PNC Financial documents, (a) for copies without exhibits, by contacting Shareholder Services at 800-982-7652 or via the online contact form at wwww.computershare.com/contactus, and (b) for exhibits, by contacting Shareholder Relations at 800-843-2206 or via e-mail at investor.relations@pnc.com. The interactive data file ("XBRL") exhibit is only available electronically.

APPENDIX G-3

U. S. BANK NATIONAL ASSOCIATION

U.S. Bank National Association ("USBNA") is a national banking association organized under the laws of the United States and is the largest subsidiary of U.S. Bancorp. At June 30, 2011, USBNA reported total assets of $310 billion, total deposits of $219 billion and total shareholders' equity of $34 billion. The foregoing financial information regarding USBNA has been derived from and is qualified in its entirety by the unaudited financial information contained in the Federal Financial Institutions Examination Council report Form 031, Consolidated Report of Condition and Income for a Bank with Domestic and Foreign Offices ("Call Report"), for the quarter ended June 30, 2011. The publicly available portions of the quarterly Call Reports with respect to USBNA are on file with, and available upon request from, the FDIC, 550 17th Street, NW, Washington, D.C. 20429 or by calling the FDIC at (877) 275-3342. The FDIC also maintains an Internet website at www.fdic.gov that contains reports and certain other information regarding depository institutions such as USBNA. Reports and other information about USBNA are available to the public at the offices of the Comptroller of the Currency at One Financial Place, Suite 2700, 440 South LaSalle Street, Chicago, IL 60605.

U.S. Bancorp is subject to the informational requirements of the Securities Exchange Act of 1934, as amended, and, in accordance therewith, files reports and other information with the Securities and Exchange Commission (the "SEC"). U.S. Bancorp is not guaranteeing the obligations of USBNA and is not otherwise liable for the obligations of USBNA.

Except for the contents of this appendix, USBNA and U.S. Bancorp assume no responsibility for the nature, contents, accuracy or completeness of the information set forth in this Official Statement.

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APPENDIX H

BOOK-ENTRY ONLY SYSTEM

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BOOK-ENTRY ONLY SYSTEM

The description which follows of the procedures and recordkeeping with respect to beneficial ownership interests in the Bonds, payments of principal of and premium, if any, and interest on the Bonds to The Depository Trust Company, New York, New York, its nominee, Participants or Beneficial Owners (each as hereinafter defined), confirmation and transfer of beneficial ownership interests in the Bonds and other bond-related transactions by and between DTC, Participants and Beneficial Owners is based solely on information furnished by DTC.

DTC will act as securities depository for the Bonds. The Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Bond certificate will be issued for each Series of the Bonds, each in the aggregate principal amount of such issue, and will be deposited with DTC.

DTC, the world's largest depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non-U.S. equity, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants (the "Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has a Standard & Poor's rating of AA+. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of the Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC's records. The ownership interest of each actual purchaser of each Bond (the "Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners, however, are expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Bonds are to be accomplished by entries made on the books of Direct or Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in the Bonds, except in the event that use of the book-entry system for the Bonds is discontinued.

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holding on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time.

Redemption notices shall be sent to DTC. If less than all of the Bonds are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such issue to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Bonds unless authorized by a Direct Participant in accordance with DTC's Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to each of the respective Issuer or the Alliance, as applicable, as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Redemption proceeds, distributions, and dividend payments on the Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Alliance or the Bond Trustee on a payment date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC, the Bond Trustee, each of the Issuers or the Alliance, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds, distributions, and dividend payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Alliance or the Bond Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as securities depository with respect to the Bonds at any time by giving reasonable notice to the respective Issuer or the Alliance. Under such circumstances, in the event that a successor securities depository is not obtained, Bond certificates will be printed and delivered.

The respective Issuer or the Alliance may decide to discontinue the respective Issuer's use of the system of book-entry transfers through DTC (or a successor securities depository). In that event, Bond certificates will be printed and delivered.

The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the respective Issuer believes to be reliable, but the respective Issuer takes no responsibility for the accuracy thereof.

Neither the respective Issuer nor the Registrar has any responsibility or obligation to the Direct or Indirect Participants or the Beneficial Owners with respect to (a) the accuracy of any records maintained by DTC or any Direct or Indirect Participant; (b) the payment by any Direct or Indirect Participant of any amount due to any Beneficial Owner in respect of the principal of and interest on the Bonds; (c) the delivery or timeliness of delivery by any Direct or Indirect Participant of any notice to any Beneficial Owner that is required or permitted under the terms of the Bond Resolution to be given to Bondholders; or (d) any other action taken by DTC, or its nominee, Cede & Co., as Bondholder, including the effectiveness of any action taken pursuant to an Omnibus Proxy.

So long as Cede & Co. is the registered owner of the Bonds, as nominee of DTC, references in this Official Statement to the Owners of the Bonds shall mean Cede & Co. and shall not mean the Beneficial Owners, and Cede & Co. will be treated as the only holder of Bonds for all purposes under the Bond Resolution.

The respective Issuer may enter into amendments to the agreement with DTC or successor agreements with a successor securities depository, relating to the book-entry system to be maintained with respect to the Bonds without the consent of Beneficial Owners or Bondholders.

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Exhibit 11.4

Attachment B

Mountain States Bonds Official Statement for 2012 Bonds

NEW ISSUE - Book-Entry Only **Ratings: (See "RATINGS")**

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described in "TAX MATTERS," interest on the Series 2012A Bonds (a) will not be included in gross income for federal income tax purposes, and (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations; such interest, however, is taken into account in determining the adjusted current earnings for purposes of the alternative minimum tax on corporations. Interest on the Series 2012A Bonds will be exempt from all state, county and municipal taxation in Tennessee except inheritance, transfer, estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes. A holder may be subject to other federal tax consequences as described in "TAX MATTERS."

$55,000,000
THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF THE CITY OF JOHNSON CITY, TENNESSEE
HOSPITAL REVENUE BONDS
(MOUNTAIN STATES HEALTH ALLIANCE)
SERIES 2012A

Dated: Date of Delivery **Maturity: As shown on inside cover page**

At the request of Mountain States Health Alliance, a Tennessee non-profit corporation (the "Alliance"), The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer") is issuing its $55,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012A (the "Series 2012A Bonds"), pursuant to a Bond Trust Indenture dated as of September 1, 2012 (the "Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee"). The Series 2012A Bonds are limited obligations of the Issuer, payable from payments to be made by the Alliance to the Bond Trustee pursuant to a Loan Agreement dated as of September 1, 2012 (the "Loan Agreement"), between the Issuer and the Alliance, and pursuant to the Series 2012A Obligation, hereinafter defined, which is issued under and secured by the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the "Master Indenture"), between (1) the Alliance, Blue Ridge Medical Management Corporation, Norton Community Hospital, and Smyth County Community Hospital, and (2) The Bank of New York Mellon Trust Company, N.A., as master trustee, which provides the security for the Series 2012A Obligation.

Simultaneously with the issuance of the Series 2012A Bonds, the Issuer is issuing its approximately $30,230,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012B (the "Series 2012B Bonds"), and the Industrial Development Authority of Wise County (Virginia) is issuing its approximately $9,790,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012C (the "Series 2012C Bonds"), also for the benefit of the Alliance. The Series 2012B Bonds and the Series 2012C Bonds are being sold pursuant to a separate Official Statement.

The Series 2012A Bonds will be issued in denominations of $5,000 or any integral multiple thereof and will bear interest from the date of delivery thereof until maturity as shown on the inside cover hereof. The Series 2012A Bonds will bear interest at the rates specified on the inside cover hereof, payable on each February 15 and August 15, commencing on February 15, 2013.

The Series 2012A Bonds will be subject to redemption prior to maturity, including optional redemption, mandatory sinking fund redemption and extraordinary redemption as described herein.

The Series 2012A Bonds, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Series 2012A Bonds. Purchasers will not receive certificates representing their ownership interest in the Series 2012A Bonds purchased. Interest on the Series 2012A Bonds will accrue from the date of issuance and be payable by the Bond Trustee to DTC for the account of DTC Participants, who are responsible for crediting the accounts of the beneficial owners.

The Series 2012A Bonds will be limited obligations of the Issuer, payable solely from the sources described in this Official Statement and will not constitute or create any debt, liability or obligation of the State of Tennessee or any political subdivision or agency thereof or a pledge of the faith and credit of the State of Tennessee or any political subdivision or agency thereof. Neither the faith and credit nor taxing power of any state or any political subdivision or agency thereof will be pledged to the payment of the Series 2012A Bonds.

This cover page contains certain information for quick reference only. It is not a summary of this issue. Investors must read the entire Official Statement to obtain information necessary to make an informed investment decision. For a description of certain risk factors relating to the Series 2012A Bonds, see "CERTAIN RISK FACTORS."

The Series 2012A Bonds are offered when, as and if issued, subject to the approving opinion of Bass, Berry & Sims PLC, Nashville and Knoxville, Tennessee, as Bond Counsel, and certain other conditions. In connection with the issuance of the Series 2012A Bonds, certain legal matters will be passed upon by Anderson & Fugate, Johnson City, Tennessee, as counsel to the Alliance, Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Issuer, and Hunton & Williams LLP, as Underwriter's Counsel. The Public Advisory Corporation serves as financial advisor to the Alliance. It is expected that the Series 2012A Bonds will be issued and available for delivery to DTC in New York, New York, on or about September 18, 2012.

BofA Merrill Lynch

Dated: August 24, 2012

SERIES 2012A BONDS

$55,000,000 5.000% Term Bonds due August 15, 2042, priced at 103.391% to yield 4.570% *, CUSIP 478271 JV2**

*Yield calculated based on the Series 2012A Bonds being priced to the first optional redemption date (8/15/2022).

**CUSIP numbers have been assigned by an organization not affiliated with the Issuer or the Alliance and are included solely for the convenience of the holders of the Series 2012A Bonds. The Issuer and the Alliance are not responsible for the selection or use of these CUSIP numbers, nor is any representation made as to their correctness on the Series 2012A Bonds or as indicated above.

No dealer, salesperson, or other person has been authorized to give any information or to make any representation, other than the information contained in this Official Statement, in connection with the offering of the Series 2012A Bonds, and, if given or made, such information or representation must not be relied upon as having been authorized by the Issuer, the Alliance or the Underwriter. The information in this Official Statement is subject to change without notice, and neither the delivery of this Official Statement nor any sale hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the Issuer, the Alliance or others since the date hereof. This Official Statement does not constitute an offer or solicitation in any jurisdiction in which such offer or solicitation is not authorized, or in which any person making such offer or solicitation is not qualified to do so, or to any person to whom it is unlawful to make such offer or solicitation. The information set forth herein has been obtained from the Issuer, the Alliance and other sources that are believed to be reliable, but it is not guaranteed as to accuracy or completeness by the Underwriter.

THE PRICES AT WHICH THE SERIES 2012A BONDS ARE OFFERED TO THE PUBLIC BY THE UNDERWRITER MAY VARY FROM THE INITIAL PUBLIC OFFERING PRICES APPEARING ON THE FOREGOING PAGE. IN ADDITION, THE UNDERWRITER MAY ALLOW CONCESSIONS OR DISCOUNTS TO DEALERS AND OTHER FROM THE PRICES AT WHICH THE SERIES 2012A BONDS ARE OFFERED TO THE PUBLIC. IN CONNECTION WITH THE OFFERING OF THE SERIES 2012A BONDS, THE UNDERWRITER MAY EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICE OF THE SERIES 2012A BONDS AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

THE SERIES 2012A BONDS WILL NOT BE REGISTERED BY THE ISSUER OR THE ALLIANCE UNDER THE SECURITIES ACT OF 1933, AS AMENDED, OR ANY STATE SECURITIES LAW AND WILL NOT BE LISTED ON ANY STOCK OR OTHER SECURITIES EXCHANGE. NEITHER THE SECURITIES AND EXCHANGE COMMISSION NOR ANY OTHER FEDERAL, STATE, MUNICIPAL, OR OTHER GOVERNMENTAL ENTITY OR AGENCY SHALL HAVE PASSED UPON THE ACCURACY OR ADEQUACY OF THIS OFFICIAL STATEMENT.

IN MAKING ANY INVESTMENT DECISION, INVESTORS MUST RELY ON THEIR OWN EXAMINATION OF THE TERMS OF THE OFFERING, INCLUDING THE MERITS AND RISKS INVOLVED. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY ANY FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

THIS OFFICIAL STATEMENT CONTAINS FORWARD-LOOKING STATEMENTS THAT ARE SUBJECT TO A NUMBER OF RISKS AND UNCERTAINTIES, INCLUDING THOSE DESCRIBED IN "CERTAIN RISK FACTORS," MANY OF WHICH ARE BEYOND THE ISSUER'S AND THE ALLIANCE'S CONTROL. FORWARD-LOOKING STATEMENTS ARE TYPICALLY IDENTIFIED BY WORDS SUCH AS "BELIEVE," "EXPECT," "ANTICIPATE," "INTEND," "ESTIMATE" AND SIMILAR EXPRESSIONS. ACTUAL RESULTS COULD DIFFER MATERIALLY FROM THOSE CONTEMPLATED BY THESE FORWARD-LOOKING STATEMENTS AS A RESULT OF FACTORS ("CAUTIONARY STATEMENTS") SUCH AS THOSE DESCRIBED IN "CERTAIN RISK FACTORS" HEREIN. IN LIGHT OF THESE RISKS AND UNCERTAINTIES, THERE CAN BE NO ASSURANCE THAT THE RESULTS AND EVENTS CONTEMPLATED BY THE FORWARD-LOOKING INFORMATION CONTAINED IN THIS OFFICIAL STATEMENT WILL IN FACT TRANSPIRE. YOU ARE CAUTIONED NOT TO PLACE UNDUE RELIANCE ON THESE FORWARD-LOOKING STATEMENTS. NEITHER THE ISSUER NOR THE ALLIANCE UNDERTAKE ANY OBLIGATION TO UPDATE OR REVISE ANY FORWARD-LOOKING STATEMENTS. ALL SUBSEQUENT WRITTEN OR ORAL FORWARD-LOOKING STATEMENTS ATTRIBUTABLE TO THE ISSUER AND THE ALLIANCE OR PERSONS ACTING ON THEIR BEHALF ARE EXPRESSLY QUALIFIED IN THEIR ENTIRETY BY THE CAUTIONARY STATEMENTS.

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OFFICIAL STATEMENT

INTRODUCTION

The Series 2012A Bonds

This Official Statement, including its cover page and appendices, provides information in connection with the issuance and sale by The Health and Educational Facilities Board of the City of Johnson City, Tennessee (the "Issuer") of its $55,000,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012A (the "Series 2012A Bonds"), for the benefit of Mountain States Health Alliance (the "Alliance"). The Series 2012A Bonds are issued pursuant to a Bond Trust Indenture dated as of September 1, 2012 (the "Bond Indenture"), between the Issuer and The Bank of New York Mellon Trust Company, N.A., New York, New York, as bond trustee (the "Bond Trustee"), and the proceeds thereof will be loaned to the Alliance pursuant to a Loan Agreement dated as of September 1, 2012 (the "Loan Agreement"), between the Issuer and the Alliance.

This introduction is not a summary of this Official Statement. It is only a summary description of and guide to, and is qualified by, more complete and detailed information contained in the entire Official Statement, including the cover page and appendices hereto, and the documents summarized or described herein. A full review should be made of the entire Official Statement. The offering of the Series 2012A Bonds to potential investors is made only by means of the entire Official Statement.

The Alliance

The Mountain States Health Alliance (the "Alliance") is a Tennessee nonprofit corporation that is an "exempt organization" under Section 501(c)(3) of the Internal Revenue Code of 1986 (the "Code"). The Alliance provides an integrated, comprehensive continuum of care to people in portions of Tennessee, Virginia, Kentucky, and North Carolina. The Alliance currently operates 13 hospital facilities containing a total of 1,623 licensed beds, and serves a population of more than 1,000,000 in 29 counties and two independent cities in the States of Tennessee, Virginia, Kentucky and North Carolina. Its integrated health care delivery system also includes 23 primary/preventive care centers and 12 outpatient care sites. **For additional information regarding the Alliance, see Appendix A.**

The Obligated Issuers

The Alliance, Blue Ridge Medical Management Corporation ("Blue Ridge"), Norton Community Hospital ("Norton") and Smyth County Community Hospital ("Smyth") are each an Obligated Issuer as such term is used in the Amended and Restated Master Trust Indenture dated as of February 1, 2000, as amended (the "Master Indenture"), between (1) the Alliance, Blue Ridge, Norton, and Smyth, and (2) The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"). Only the Obligated Issuers are obligated to make payments on the Series 2012A Bonds. See Appendix A - "HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates" and "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

Plan of Finance

The proceeds of the Series 2012A Bonds are being loaned to the Alliance pursuant to the Loan Agreement and will be used by the Alliance to (1) finance a surgery center project at the Alliance hospital in Johnson City, Tennessee; and (2) pay certain expenses incurred in connection with the issuance of the Series 2012A Bonds. See "PLAN OF FINANCE."

Book-Entry Registration

The Series 2012A Bonds initially will be issued in the form of one registered bond in the aggregate principal amount of each maturity of each Series and will be registered in the name of Cede & Co., as nominee for The Depository Trust Company, New York, New York ("DTC"). DTC will maintain a book-entry system for recording ownership interest in the Series 2012A Bonds. Purchasers will not receive certificates representing their

ownership interest in the Series 2012A Bonds purchased. Principal of, any redemption price for, and interest on the Series 2012A Bonds will be payable by the Bond Trustee to DTC for the account of DTC Participants (as defined herein), who are responsible for crediting the accounts of the beneficial owners. See Appendix F - "BOOK-ENTRY ONLY SYSTEM."

Sources of Payment and Security for the Series 2012A Bonds

The Series 2012A Bonds shall not constitute a debt or obligation of the State of Tennessee or any political subdivision or agency thereof or a pledge of the faith and credit of any state or any political subdivision or agency of any state, including the Issuer. The Series 2012A Bonds are special, limited obligations of the Issuer, payable from the Trust Estate as described in "THE SERIES 2012A BONDS - General" and "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS - Trust Estate."

To evidence the Alliance's repayment obligations in connection with the Series 2012A Bonds, the Alliance will issue its $55,000,000 Mountain States Health Alliance Note (The Health and Educational Facilities Board of the City of Johnson City, Tennessee) Series 2012A (the "Series 2012A Obligation"), pursuant to the Master Indenture.

In the Master Indenture, the Alliance and the other Obligated Issuers have covenanted, and any future Obligated Issuer would be required to covenant, to operate its facilities in such a manner and to charge such fees and rates as will be sufficient to provide funds (together with other available amounts) to pay debt service on its outstanding indebtedness, to pay certain other expenses and indebtedness of the Alliance and all future Obligated Issuers, and to maintain a coverage ratio of Income Available for Debt Service to Maximum Annual Debt Service equal to at least 1.30:1. For a description of such covenants, including exceptions thereto, see "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS" and Appendix C - "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE."

Certain existing bonds of the Issuer and other issuers, as well as bonds of the Alliance, previously have been issued and are secured by Obligations issued by the Alliance under the Master Indenture ("Master Obligations") and therefore are secured on a parity with the Series 2012A Bonds. The Alliance and any future Obligated Issuer have the right, subject to specified conditions, to incur additional indebtedness on a parity with the Series 2012A Obligation and the Series 2012A Bonds. See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS - Additional Indebtedness."

No Debt Service Reserve Fund

The Series 2012A Bonds are not secured by any Debt Service Reserve Fund.

Tax Matters

In the opinion of Bass, Berry & Sims PLC, Bond Counsel, under existing law and subject to conditions described under "TAX MATTERS," interest on the Series 2012A Bonds (a) will not be included in gross income for federal income tax purposes and (b) will not be an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations; however, such interest on the Series 2012A Bonds is taken into account in determining a corporation's alternative minimum income tax. In the opinion of Bond Counsel, interest on the Series 2012A Bonds will be exempt from all state, county, and municipal taxation in the State of Tennessee except inheritance, gift, and estate taxes and except that interest may not be exempt from Tennessee franchise and excise taxes. Holders of Series 2012A Bonds may be subject to other federal tax consequences, as described herein under "TAX MATTERS."

Continuing Disclosure

To permit compliance with Rule 15c2-12 promulgated under the Securities Exchange Act of 1934 ("Rule 15c2-12"), the Alliance will execute a Continuing Disclosure Agreement in connection with the issuance of the Series 2012A Bonds in which it will agree for the benefit of the holders of the Series 2012A Bonds to provide

certain annual financial information and operating data and certain quarterly financial data as to the Alliance and any future Obligated Issuer under the Master Indenture, and to provide notice of certain enumerated events, if material. See "CONTINUING DISCLOSURE AGREEMENT" for a more complete description of the Continuing Disclosure Agreement and the Alliance's performance under previous continuing disclosure agreements.

Professionals Involved in the Offering

Bass, Berry & Sims PLC will act as Bond Counsel in connection with the issuance of the Series 2012A Bonds. In connection with the issuance of the Series 2012A Bonds, certain legal matters will be passed upon by Anderson & Fugate, Johnson City, Tennessee, as counsel to the Alliance, Samuel B. Miller, Esq., Johnson City, Tennessee, as counsel to the Issuer, and Hunton & Williams LLP, as Underwriter's Counsel. The Alliance's consolidated financial statements for the fiscal years ended June 30, 2011 and 2010, included in Appendix B hereto, have been audited by Pershing Yoakley & Associates, P.C.

Relationships of the Parties

The Alliance has entered into interest rate exchange agreements, or swap agreements, with Bank of America, which is an affiliate of Bank of America Merrill Lynch, underwriter for the Series 2012A Bonds.

Acceleration

Subject to certain conditions, the Series 2012A Bonds are subject to acceleration of the maturity date upon the happening of an Event of Default under the Master Indenture and the Bond Indenture. See "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE" and "- SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE" in Appendix C.

Bondholders' Risks

Payment of the Series 2012A Bonds is dependent on the ability of the Alliance and the other Obligated Issuers to make payments under the Loan Agreement and the Master Indenture. The Alliance's ability to make such payments may be adversely affected by many factors. There may also be legal and practical limitations on the enforcement of remedies and amounts that may be realized upon enforcement of remedies available to the Bond Trustee and owners of the Series 2012A Bonds. See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS" and "CERTAIN RISK FACTORS" herein and "SOURCES OF REVENUE" in Appendix A.

Legal Document Summaries and Definitions

Certain provisions of the Master Indenture, the Bond Indenture and the Loan Agreement are summarized in Appendix C hereto. Other definitions of certain terms used in this Official Statement are also set forth in Appendix C hereto.

Other Information

This Official Statement speaks only as of its date, and the information contained herein is subject to change.

The quotations from, and summaries and explanations of, the statutes, regulations and documents referenced herein do not purport to be complete and reference is made to those statutes, regulations and documents for full and complete statements of their provisions. Copies, in reasonable quantity, of such documents may be obtained during the offering period, upon request to the Alliance and upon payment to the Alliance of a charge for copying, mailing and handling, at 400 North State of Franklin Road, Johnson City, TN 37604-6094, Attn: Legal Department.

Purchasers of the Series 2012A Bonds should note the use of forward-looking information and the covenants related thereto.

Any statements in this Official Statement involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact. This Official Statement is not to be construed as a contract or agreement between the Issuer or the Alliance and the purchasers or holders of any of the Series 2012A Bonds.

This introduction is not a summary of this Official Statement. It is only a summary description of and guide to, and is qualified by, more complete and detailed information contained in the entire Official Statement, including the cover page and appendices hereto, and the documents summarized or described herein. A full review should be made of the entire Official Statement. The offering of Series 2012A Bonds to potential investors is made only by means of the entire Official Statement.

THE ISSUER

The Issuer is a public nonprofit corporation organized under the laws of the State of Tennessee. The Issuer was incorporated on May 3, 1973, by the Board of Commissioners of the City of Johnson City, Tennessee, pursuant to the laws now codified under Tennessee Code Annotated Section 48-101-301, *et seq.* (the "Tennessee Act"). The Tennessee Act authorizes the Issuer, among other things, to issue its bonds, to acquire, improve, maintain, extend, equip and furnish hospital facilities either within or without the corporate limits of the City of Johnson City, and in certain other jurisdictions in Tennessee, to mortgage its projects, to pledge the revenues and receipt therefrom, and to sell, exchange, donate and convey any or all of its properties. The Issuer has no taxing power.

THE ALLIANCE

The Alliance is a Tennessee nonprofit corporation recognized by the Internal Revenue Service as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 (the "Code"). Today, the Alliance directly and through related entities provides an integrated, comprehensive continuum of care to people in 29 counties and two independent cities in Tennessee, Virginia, Kentucky and North Carolina. The Alliance was initially incorporated as Memorial Hospital on April 12, 1945, as a non-sectarian, general welfare, not-for-profit corporation. In connection with the relocation of its operations, it changed its name to Johnson City Medical Center Hospital, Inc. in 1983. In 1998, Johnson City Medical Center Hospital, Inc. assumed operating responsibility for five hospitals and related assets acquired from Columbia/HCA. In recognition of its expanded facilities and scope of services resulting from the 1998 acquisition, Johnson City Medical Center Hospital, Inc. changed its name to Mountain States Health Alliance.

The Alliance currently owns or controls the following facilities:

Facility	Location
Johnson City Medical Center	Johnson City, TN
James H. & Cecile Quillen Rehabilitation Hospital	Johnson City, TN
Woodridge Hospital	Johnson City, TN
Franklin Woods Community Hospital	Johnson City, TN
Indian Path Medical Center	Kingsport, TN
Sycamore Shoals Hospital	Elizabethton, TN
Johnson County Community Hospital	Mountain City, TN
Smyth County Community Hospital[(1)]	Marion, VA
Norton Community Hospital[(2)]	Norton, VA
Dickenson Community Hospital[(2)]	Clintwood, VA
Russell County Medical Center	Lebanon, VA
Johnston Memorial Hospital[(2)]	Abingdon, VA

(1) 80% membership interest held by the Alliance.
(2) 50.1% membership interest held by the Alliance.

The Alliance now has a total of 1,623 licensed beds serving a population of more than 1,000,000. In addition to its hospitals, the Alliance's integrated health care delivery system includes 23 primary/preventive care centers and 12 outpatient care sites. The Alliance's medical facilities provide a full spectrum of general and specialty medical services, including rehabilitative services for individuals with brain injuries, strokes and spinal cord injuries, in-patient psychiatric services and centers for health focusing on cardiovascular health, pulmonary medicine, women's health and cancer therapy, among other services. The Alliance also serves as a clinical training facility for medical students, residents, and nursing students from the East Tennessee State University's James H. Quillen College of Medicine and the School of Public and Allied Health. **For additional information regarding the Alliance, see Appendix A.**

The Alliance, Blue Ridge, Norton and Smyth are each an Obligated Issuer as such term is used in the Master Indenture. Blue Ridge is a wholly-owned, for-profit subsidiary of the Alliance. Norton is a Virginia non-stock corporation in which the Alliance owns a 50.1% interest. Smyth is a Virginia non-stock corporation in which the Alliance owns an 80% interest. See Appendix A - "HISTORY AND OVERVIEW - Operations of Subsidiary and Other Affiliates."

The Alliance also operates the hospital facilities in Dickenson County and Washington County, Virginia, through ownership of a majority interest in the membership of the corporations owning such facilities. None of such corporations are an Obligated Issuer or otherwise are responsible for repayment of amounts due from the Alliance with respect to the Series 2012A Bonds, and none of the assets of such corporations are pledged as security for the Alliance's payment obligations.

Only the Obligated Issuers are obligated to pay the Series 2012A Bonds. The audited and unaudited financial statements of the Alliance included as Appendices B and C reflect the assets, liabilities, revenues and expenses of related organizations that are not Obligated Issuers. See Appendix A − "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

THE SERIES 2012A BONDS

Set forth below is a summary of certain provisions of the Series 2012A Bonds. General information describing the Series 2012A Bonds appears elsewhere in this Official Statement. That information should be read in conjunction with this summary, which is qualified in its entirety by reference to the Bond Indenture, and the form of the Series 2012A Bonds. See "SUMMARY OF THE FINANCING DOCUMENTS" in Appendix C hereto.

General

The Series 2012A Bonds shall be initially issued as fully registered bonds without coupons in authorized denominations of $5,000 and integral multiples thereof. The Series 2012A Bonds will mature, subject to prior redemption as described herein, on August 15, in the years and at the fixed interest rates set forth on the inside cover of this Official Statement, with such interest payable on February 15 and August 15 of each year, commencing February 15, 2013.

The Series 2012A Bonds initially will be dated the date of issuance thereof. Except as described in the next sentence, subsequently issued Series 2012A Bonds will be dated as of the later of the date of original issuance of the Series 2012A Bonds or the most recent preceding interest payment date to which interest has been paid thereon. Series 2012A Bonds issued on an interest payment date to which interest has been paid will be dated as of such date. For a description of method of payment of principal, premium, if any and interest on the Series 2012A Bonds and matters pertaining to transfers and exchange while registered in the name of Cede & Co., see "BOOK-ENTRY ONLY SYSTEM" in Appendix F.

The principal and premium, if any, of the Series 2012A Bonds shall be payable at the office of the Bond Trustee in East Syracuse, New York, upon surrender of the Series 2012A Bonds at such office. Interest on the Series 2012A Bonds (other than Defaulted Interest) shall be payable by check or draft drawn upon the Bond Trustee (or, as to any owner of $1,000,000 or more in aggregate principal amount of Series 2012A Bonds who so elects, by wire transfer of funds to such wire transfer address within the continental United States as the registered owner shall

have furnished to the Bond Trustee in writing) and paid to the Persons in whose names the Series 2012A Bonds are registered on the Bond Register maintained by the Bond Trustee as of the close of business on the Record Date (each February 1 and August 1) next preceding the relevant interest payment date. Any interest on any Series 2012A Bond which is payable but which is not punctually paid or duly provided for on the due date ("Defaulted Interest") shall cease being payable to the person in whose name such Bond is registered on the Record Date and instead shall be payable to the person in whose name such Bond is registered at close of business on a Special Record Date selected by the Bond Trustee and which shall be at least 10 days but not more than 15 days before the date selected by the Alliance for payment of such Defaulted Interest. The Bond Trustee shall give Notice by Mail of the Special Record Date and date for payment of Defaulted Interest at least 10 days before the Special Record Date.

THE SERIES 2012A BONDS ARE, AND ARE TO BE, EQUALLY AND RATABLY SECURED, TO THE EXTENT PROVIDED IN THE BOND INDENTURE, SOLELY BY A PLEDGE OF THE REVENUES AND OTHER FUNDS PLEDGED UNDER THE BOND INDENTURE. THE SERIES 2012A BONDS, TOGETHER WITH PREMIUM, IF ANY, AND THE INTEREST THEREON, ARE SPECIAL AND LIMITED OBLIGATIONS OF THE ISSUER. THE SERIES 2012A BONDS AND THE INTEREST THEREON SHALL NOT BE DEEMED TO CONSTITUTE A DEBT OR A PLEDGE OF THE FAITH AND CREDIT OF THE STATE OF TENNESSEE OR ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE CITY OF JOHNSON CITY, TENNESSEE. THE CITY OF JOHNSON CITY, TENNESSEE, SHALL NOT IN ANY EVENT BE LIABLE FOR THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE SERIES 2012A BONDS, OR FOR THE PERFORMANCE OF ANY PLEDGE, MORTGAGE, OBLIGATION OR AGREEMENT OF ANY KIND WHATSOEVER THEREIN OR INDEBTEDNESS BY THE ISSUER, AND NEITHER THE SERIES 2012A BONDS NOR ANY OF THE ISSUER'S AGREEMENTS OR OBLIGATIONS DESCRIBED IN THE SERIES 2012A BONDS OR OTHERWISE SHALL BE CONSTRUED TO CONSTITUTE AN INDEBTEDNESS OF THE CITY OF JOHNSON CITY, TENNESSEE, WITHIN THE MEANING OF ANY CONSTITUTIONAL OR STATUTORY PROVISIONS WHATSOEVER. THE ISSUER HAS NO TAXING AUTHORITY.

Registration of Transfer or Exchange of Series 2012A Bonds

The Bond Indenture contains the following provisions with respect to registration of transfer or exchange of Series 2012A Bonds. Such provisions do not apply while the Series 2012A Bonds are held by DTC. See Appendix F - "BOOK-ENTRY ONLY SYSTEM."

Only upen surrender for transfer of any Series 2012A Bond at the corporate trust office of the Bond Trustee in East Syracuse, New York, shall the Issuer execute and the Bond Trustee authenticate and deliver in the name of the transferee or transferees a new fully registered Series 2012A Bond or Series 2012A Bonds of the same series and maturity and of authorized denomination for the aggregate principal amount which the registered owner is entitled to receive.

Any Series 2012A Bond or Series 2012A Bonds may be exchanged at said office of the Bond Trustee for a like aggregate principal amount of Series 2012A Bond or Series 2012A Bonds of the same series and maturity of other authorized denominations. The execution by the Issuer of any Series 2012A Bond shall constitute full and due authorization of such Series 2012A Bond, and the Bond Trustee shall thereby be authorized to authenticate, date and deliver such Series 2012A Bond.

All Series 2012A Bonds presented for transfer or exchange shall be accompanied by a written instrument or instruments of transfer or authorization for exchange, in form and with guaranty of signature satisfactory to the Bond Trustee, duly executed by the registered owner or by such owner's duly authorized attorney.

No service charge shall be imposed for any exchange or transfer of Series 2012A Bonds. The Issuer and the Bond Trustee may, however, require payment by the person requesting an exchange or transfer of Series 2012A Bonds of a sum sufficient to cover any tax, fee or other governmental charge that may be imposed in relation thereto, except in the case of the issuance of a Series 2012A Bond or Series 2012A Bonds for the unredeemed portion of a Series 2012A Bond surrendered for redemption.

The Issuer and the Bond Trustee shall not be required to register the transfer of or exchange any Series 2012A Bond after notice calling such Series 2012A Bond or portion thereof for redemption has been mailed or

during the 15 day period next preceding the mailing of a notice of redemption of any Series 2012A Bonds of the same series and maturity.

New Series 2012A Bonds delivered upon any transfer or exchange shall be valid obligations of the Issuer, evidencing the same debt as the Series 2012A Bonds surrendered, shall be secured by the Bond Indenture and shall be entitled to all of the security and benefits thereof to the same extent as the Series 2012A Bond surrendered.

The Issuer and the Bond Trustee may treat the registered owner of any Series 2012A Bond as the absolute owner thereof for all purposes, whether or not such Series 2012A Bond shall be overdue, and shall not be bound by any notice to the contrary. All payments of or on account of the principal of and premium, if any, and interest on any such Series 2012A Bond as herein provided shall be made only to or upon the written order of the registered owner thereof or his legal representative, but such registration may be changed as herein provided. All such payments shall be valid and effectual to satisfy and discharge the liability upon such Series 2012A Bond to the extent of the sum or sums so paid.

Redemption

The Series 2012A Bonds may not be called for redemption except as described below. The Series 2012A Bonds are subject to optional redemption, extraordinary redemption and mandatory sinking fund redemption prior to maturity as described below.

Optional Redemption. The Series 2012A Bonds are subject to redemption prior to maturity on or after August 15, 2022, upon direction of the Alliance, in whole at any time, or in part (and, if in part, by maturities or portions thereof designated by the Alliance) from time to time on any interest payment date, at the redemption price of 100% of the outstanding principal amount thereof, plus accrued interest thereon to the date of redemption. No redemption of less than all of the Series 2012A Bonds at the time outstanding shall be made pursuant to the foregoing unless the aggregate principal amount to be redeemed is equal to or more than $100,000.

Extraordinary Redemption. The Series 2012A Bonds are callable for extraordinary redemption prior to maturity in the event of damage to or destruction of the Property of any member of the Obligated Group or any part thereof or condemnation of the Facilities or any part thereof, if the net proceeds of insurance or condemnation received in connection therewith after expenses of recovery of such proceeds to the extent such net proceeds are not applied either to any lawful purposes of the Obligated Group or to the repair, replacement, restoration or reconstruction of the affected Facilities pursuant to the Master Indenture, but only to the extent of the funds provided for in the Master Indenture. If thus called for redemption, the Series 2012A Bonds shall be subject to redemption by the Issuer at any time, in whole or in part, and if in part, the Alliance may decide the amount of Series 2012A Bonds to be redeemed and the order of maturity or portion of each maturity within such Series to be redeemed, and within such maturity of such Series, the Bond Trustee shall select the bonds to be redeemed by lot. Such redemption shall be at the principal amount thereof plus accrued interest to the redemption date, and without premium, from the proceeds of such insurance or condemnation award or such sale but not in excess of the amount of such proceeds applied to such purpose. If no direction is given by the Alliance, the Bond Trustee will redeem Series 2012A Bonds and each Series of Additional Bonds then outstanding under the Bond Indenture pro rata based on the then outstanding principal amount of each Series under the Bond Indenture and within each Series will redeem bonds in the inverse order of maturity thereof. No redemption of less than all of the Series 2012A Bonds at the time outstanding shall be made pursuant to the foregoing unless the aggregate principal amount to be redeemed is equal to or more than $100,000.

Purchase of Bonds. In lieu of redeeming Series 2012A Bonds, the Bond Trustee may, at the request of the Issuer, use such funds otherwise available under the Bond Indenture for optional or extraordinary redemption of Series 2012A Bonds to purchase such Bonds in the open market at a price not exceeding the redemption price then applicable under the Bond Indenture. In the case of any extraordinary redemption or any purchase and cancellation of the Series 2012A Bonds, the Issuer shall receive credit against its required deposits to the Bond Sinking Fund with respect to Series 2012A Bonds of the maturity redeemed or purchased in such order as the Issuer elects prior to such extraordinary redemption or purchase and cancellation or, if no election is made, in the inverse order thereof.

Credit Against Bond Sinking Fund Deposits. In the case of any extraordinary redemption or any purchase and cancellation of the Series 2012A Bonds, the Issuer shall receive credit against its required Bond Sinking Fund deposits with respect to Series 2012A Bonds in such order as the Alliance elects prior to such extraordinary redemption or purchase and cancellation or, if no election is made, in the inverse order thereof.

Mandatory Sinking Fund Redemption. With respect to the payment of the Series 2012A Bonds by maturities or mandatory redemption through the Bond Sinking Fund, the Issuer (to the extent funds are available through the Revenue Fund held under the Bond Indenture) shall cause the Alliance to have on deposit in the Bond Sinking Fund on August 15 of each of the following years moneys to be applied to the redemption of Series 2012A Bonds in the amounts and at the times, respectively, as follows:

Payment of Series 2012A Bonds at Maturity and Pursuant to Mandatory Bond Sinking Fund Redemption

Year	Principal Amount	Year	Principal Amount
2039	$12,735,000	2041	14,075,000
2040	13,390,000	2042*	14,800,000

*At maturity

Such amounts set forth above shall be reduced (i) by the principal amount of Series 2012A Bonds acquired and delivered in satisfaction of such Bond Sinking Fund requirements and (ii) in connection with a redemption of all or a portion of the Series 2012A Bonds if the Alliance elects to reduce mandatory Bond Sinking Fund redemptions for the Series 2012A Bonds in the manner described in "THE SERIES 2012A BONDS—Redemption−*Credit Against Bond Sinking Fund Deposits"* above.

Moneys on deposit in the Bond Sinking Fund on August 15 of each of the years 2039 through 2041 shall be applied to redeem Series 2012A Bonds maturing August 15, 2042, in the respective amounts indicated in the table above, by lot in such manner as may be designated by the Bond Trustee, upon the notice, and in the manner provided in the Bond Indenture. Moneys on deposit in the Bond Sinking Fund on August 15, 2042, shall be applied to the payment of Series 2012A Bonds maturing on such date.

Payment or redemption of the Series 2012A Bonds through the Bond Sinking Fund shall be without premium. In the event the Series 2012A Bonds maturing on a specific date as aforesaid have been fully paid and moneys are on deposit in the Bond Sinking Fund to redeem the Series 2012A Bonds maturing on that specific maturity date, then such moneys on deposit in the Bond Sinking Fund shall be applied to Series 2012A Bonds maturing on the next succeeding maturity date in the order above set forth.

Notice of Redemption. The Bond Trustee shall cause notice of the call for any such redemption identifying the Series 2012A Bonds to be redeemed to be sent not less than 30 nor more than 60 days prior to the redemption date (a) by first-class mail postage prepaid, to the holder of each such Series 2012A Bond to be redeemed at his address as it appears on the registration books of the Bond Trustee, (b) by first-class mail, to at least two organizations registered with the Securities and Exchange Commission as securities depositories, and (c) to at least one information service of national recognition which disseminates redemption information with respect to municipal securities. Failure to give any notice described in (a), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2012A Bonds with respect to which no such failure has occurred and failure to give any notice described in (b) or (c), or any defect therein, shall not affect the validity of any proceedings for the redemption of any Series 2012A Bonds with respect to which the notice specified in (a) is correctly given. Any notice mailed as described above shall conclusively be presumed to have been given whether or not actually received by any holder. All Series 2012A Bonds called for redemption shall cease to bear interest on the specified redemption date provided funds for their redemption are on deposit at the place of payment on the date fixed for redemption.

With respect to optional redemption, such notice shall be conditional upon moneys being on deposit with the Bond Trustee on or prior to the redemption date in an amount sufficient to pay the redemption price on the redemption date. If moneys are not received, such notice shall be of no force and effect, the Bond Trustee shall not

redeem such Series 2012A Bonds and the Bond Trustee shall give notice, in the same manner in which the notice of redemption was given, that such moneys were not so received and that such Series 2012A Bonds will not be redeemed.

The notice of redemption may be in the form prepared by Bond Counsel or Counsel to the Bond Trustee. Any notice of the call for redemption of the Series 2012A Bonds shall state the following: (1) the name, including series designation, of the Series 2012A Bonds, (2) the CUSIP number, if any, and bond certificate number of the Series 2012A Bonds to be redeemed, (3) the original dated date of the Series 2012A Bonds, (4) the interest rate and stated maturity of the Series 2012A Bonds to be redeemed, (5) the date of the redemption notice, (6) the redemption date, (7) the redemption price, (8) if less than all of a Series 2012A Bond is to be redeemed, the amount of such Bond to be redeemed and (9) the address and telephone number of the principal offices of the Bond Trustee. In addition, in preparing such notice, the Bond Trustee shall take into account, to the extent applicable, the prevailing municipal securities industry standards and any regulatory statement of any federal industry standards and any regulatory statement of any federal or state administrative body having jurisdiction over the Issuer, or the municipal securities industry, including without limitation Release No. 34-23856 of the Securities and Exchange Commission, or any subsequent amending or superseding release.

Notwithstanding the foregoing, in the event that the depository for the Series 2012A Bonds is DTC, the Bond Trustee will follow the procedure for redemption, and selection of Bonds for redemption, prescribed by DTC.

Purchase of Bonds in Lieu of Redemption. In lieu of redeeming Series 2012A Bonds, the Bond Trustee may, at the request of the Alliance, use such funds otherwise available under the Bond Indenture for redemption of Bonds to purchase Bonds in the open market at a price not exceeding the redemption price then applicable under the Bond Indenture.

PLAN OF FINANCE

Application of Proceeds

The proceeds of the Series 2012A Bonds are being loaned to the Alliance pursuant to the Loan Agreement and will be used by the Alliance to (1) finance a surgery center project at the Alliance hospital in Johnson City, Tennessee; and (2) pay certain expenses incurred in connection with the issuance of the Series 2012A Bonds. The Alliance expects that, simultaneously with the issuance of the Series 2012A Bonds, (1) the Issuer will issue its $30,230,000 Hospital Revenue Bonds (Mountain States Health Alliance) Series 2012B (the "Series 2012B Bonds") and (2) the Industrial Development Authority of Wise County will issues its $9,790,000 Hospital Revenue Bonds (Mountain States Health Alliance), Series 2012C (the "Series 2012C Bonds"). The Series 2012B Bonds and the Series 2012C Bonds will be secured on a parity with the Series 2012A Bonds and all other bonds secured by Obligations under the Master Indenture.

Estimated Sources and Uses of Funds

The sources and uses of the proceeds of the Series 2012A Bonds are set forth below.

Sources of Funds	
Principal Amount	$55,000,00.00
Premium	1,865,050.00
TOTAL	$56,865,050.00
Uses of Funds	
Projects	$55,727,749.00
Costs of Issuance	1,137,301.00
TOTAL	$56,865,050.00

Current and Pro Forma Long-Term Debt

The left column of the following table reflects the total outstanding debt of the Alliance under the Master Indenture as of June 30, 2012, prior to the issuance of the Series 2012A Bonds, the Series 2012B Bonds and the Series 2012C Bonds (collectively, the "Series 2012 Bonds"). The right column of the following table shows the outstanding debt of the Alliance under the Master Indenture as of June 30, 2012, but adjusted to show the effect of the issuance of the Series 2012 Bonds. The table below and in the immediate following section does not include the indebtedness of certain entities controlled by the Alliance that are not Obligated Issuers.

Outstanding Long-Term Debt (at June 30, 2012)		Pro Forma Long-Term Debt (at June 30, 2012)	
Description	**Principal Amount**	**Description**	**Principal Amount**
Debt:		***Debt:***	
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	$32,885,459[1]	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Refunding Bonds, Series 2000A	$32,885,459[1]
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	33,230,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2000C	33,230,000
Mountain States Health Alliance Taxable Note, Series 2000D	14,315,000	Mountain States Health Alliance Taxable Note, Series 2000D	14,315,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	22,300,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2001A	22,300,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	168,990,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital First Mortgage Revenue Bonds, Series 2006A	168,990,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	26,170,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-1	26,170,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-2	102,750,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-2	102,750,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2007B-3	27,840,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2008A	13,245,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2008A	13,245,000	Industrial Development Authority of Russell County Hospital Revenue Bonds, Series 2008B	52,930,000
Industrial Development Authority of Russell County Hospital Revenue Bonds, Series 2008B	52,930,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,560,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee, Hospital Revenue Bonds, Series 2009A	5,560,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,535,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2009B	5,535,000	Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	115,955,000
Industrial Development Authority of Washington County, Virginia, Hospital Revenue Bonds, Series 2009C	115,955,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	161,935,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2010A	161,935,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	32,460,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2010B	32,460,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011A	65,260,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011A	65,260,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011B	20,000,000
The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2011B	20,000,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011C	49,875,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011C	49,875,000	Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011D	60,705,000
Industrial Development Authority of Smyth County Hospital Revenue Bonds, Series 2011D	60,705,000	Mountain States Health Alliance Taxable Bonds, Series 2011E	15,960,000
Mountain States Health Alliance Taxable Bonds, Series 2011E	15,960,000	The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2012A	55,000,000
		The Health and Educational Facilities Board of the City of Johnson City, Tennessee Hospital Revenue Bonds, Series 2012B[2]	30,230,000
		Industrial Development Authority of Wise County Hospital Revenue Bonds, Series 2012C[2]	9,790,000
Total Long-Term Debt	**$1,027,900,459**	**Total Long-Term Debt**	**$1,095,080,459**
Less: 2000 Reserve Fund	$ 7,000,000	Less: 2000 Reserve Fund	$ 7,000,000
2006A Reserve Fund	17,303,000	2006A Reserve Fund	17,303,000
NET TOTAL LONG-TERM DEBT	**$1,003,597,459**	**NET TOTAL LONG-TERM DEBT**	**$1,070,777,459**

Notes:
(1) Value of CABS accreted to July 1, 2012.
(2) Amount subject to change.

Estimated Annual Debt Service Requirements

The following table reflects the estimated outstanding debt service obligations of the Alliance on all long term indebtedness secured under the Master Indenture following the issuance of the Series 2012 Bonds. The estimated annual debt service with respect to outstanding indebtedness assumes a 3.50% interest rate on all variable rate bonds, and does not take into account any interest rate hedges that may exist or may be executed in the future.

	Estimated Annual Debt Service Requirements			Estimated Annual Debt Service on Other Long-Term Outstanding Indebtedness*	Estimated Total Annual Long-Term Debt Service Requirements
	Series 2012A		Series 2012B&C		
Year Ending June 30	Principal	Interest	Debt Service		
2013	-	$ 1,122,917	$ 490,245	$ 22,993,434	$ 24,606,596
2014	-	2,750,000	1,200,600	70,894,975	74,845,575
2015	-	2,750,000	1,963,975	68,626,588	73,340,563
2016	-	2,750,000	1,226,600	69,364,631	73,341,231
2017	-	2,750,000	1,175,850	69,408,888	73,334,738
2018	-	2,750,000	1,855,500	68,724,744	73,330,244
2019	-	2,750,000	1,854,500	68,725,406	73,329,906
2020	-	2,750,000	1,887,375	68,693,809	73,331,184
2021	-	2,750,000	2,484,975	68,095,825	73,330,800
2022	-	2,750,000	2,241,200	67,089,228	72,080,428
2023	-	2,750,000	2,200,575	66,523,184	71,473,759
2024	-	2,750,000	997,800	66,593,178	70,340,978
2025	-	2,750,000	1,303,150	68,597,894	72,651,044
2026	-	2,750,000	1,293,850	68,722,175	72,766,025
2027	-	2,750,000	1,368,275	68,673,150	72,791,425
2028	-	2,750,000	1,366,275	68,641,538	72,757,813
2029	-	2,750,000	1,359,050	68,359,638	72,468,688
2030	-	2,750,000	1,356,600	68,255,613	72,362,213
2031	-	2,750,000	1,348,925	67,953,091	72,052,016
2032	-	2,750,000	1,119,475	67,125,869	70,995,344
2033	-	2,750,000	1,443,300	63,715,113	67,908,413
2034	-	2,750,000	1,441,875	63,997,094	68,188,969
2035	-	2,750,000	1,440,000	65,088,725	69,278,725
2036	-	2,750,000	1,442,600	64,983,450	69,176,050
2037	-	2,750,000	1,439,675	64,873,100	69,062,775
2038	-	2,750,000	1,441,225	64,666,438	68,857,663
2039	-	2,750,000	1,442,175	64,773,706	68,965,881
2040	$12,735,000	2,431,625	6,963,450	-	22,130,075
2041	13,390,000	1,778,500	6,962,500	-	22,131,000
2042	14,075,000	1,091,875	6,965,700	-	22,132,575
2043	14,800,000	370,000	6,962,900	-	22,132,900
	$55,000,000	**$78,294,917**	**$68,040,195**	**$1,774,160,481**	**$1,975,495,593**

* Table does not include the debt service related to approximately $43 million of outstanding long-term indebtedness of Johnston Memorial Hospital. Johnston Memorial Hospital is not a member of the Obligated Group and the Obligated Issuers will not be required to pay debt service on such indebtedness.

JMH Financing

It is expected that shortly after the issuance of the Series 2012A Bonds, Johnston Memorial Hospital ("JMH") will enter into an approximately $18,000,000 taxable loan (the "JMH Loan") for the benefit of JMH. JMH is not a member of the Obligated Group and the Obligated Issuers will not be required to pay debt service on the JMH Loan. The JMH Loan is not included in the tables in the sections "Current and Pro Forma Long Term Debt" and "Estimated Annual Debt Service Requirements" above.

SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012A BONDS

Special, Limited Obligations of the Issuer

The Series 2012A Bonds will be issued under and secured by the Bond Indenture and are payable from moneys received by the Bond Trustee from the Alliance, as further described in "Trust Estate" below.

Trust Estate

The Series 2012A Bonds are payable from the Trust Estate under the Bond Indenture, which consists of (i) payments or prepayments to be made on the Series 2012A Obligation, and any additional obligations of the Alliance to the Issuer to the extent such additional obligations may be pledged under the Bond Indenture in the future; (ii) other payments under the Loan Agreement (other than fees and expenses payable to the Issuer and the Issuer's rights to notices and indemnification in certain circumstances); (iii) all moneys and investments held under the Bond Indenture as security for the Series 2012A Bonds (excluding funds held in the Rebate Fund established in the Bond Indenture); and (iv) in certain circumstances, proceeds from certain insurance and condemnation awards.

Pursuant to the Series 2012A Obligation, the Alliance is required to make payments to the Bond Trustee for deposit into the Revenue Fund established under the Bond Indenture, at the times and in amounts sufficient to pay the principal of and interest on the Series 2012A Bonds.

Payment of principal and interest on the Series 2012A Bonds will not be secured by any encumbrance, mortgage or other pledge of any property of any Issuer. **The Series 2012A Bonds will not constitute a debt or indebtedness of any state or any political subdivision or agency thereof, including The Health and Educational Facilities Board of the City of Johnson City, Tennessee, within the meaning of any constitutional or statutory provision or limitation. The Issuer does not have taxing power.**

Master Indenture Covenants

In the Master Indenture, the Alliance has made certain covenants, on behalf of itself and the Obligated Group (as defined in the Master Indenture), regarding maintenance of fees and rates, and any future Obligated Issuer would be required to make similar covenants upon joining the Obligated Group. These covenants provide, among other matters, that each Obligated Issuer (including the Alliance) will continue to impose such fees as are included within the Gross Revenues, operate on a revenue producing basis, and charge such fees and rates for its facilities and services and exercise such skill and diligence as to provide income from its property together with other available funds sufficient to pay promptly all payments of principal and interest on its indebtedness secured by the Master Indenture, all expenses of operation, maintenance, and repair of its property subject to the Master Indenture, and all other payments required to be made by it under the Master Indenture to the extent permitted by law. Each Obligated Issuer (including the Alliance) also covenants to use its best efforts to maintain in each Fiscal Year a ratio of total Income Available for Debt Service to Maximum Annual Debt Service for all Obligated Issuers at least equal to 1.30 to 1. Each Obligated Issuer (including the Alliance) further covenants that it will from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of the Master Indenture described in this paragraph. See Appendix C - "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges."

The Master Indenture defines "Income Available for Debt Service" of the Alliance or other Obligated Issuer to mean, with respect to any period of time, the excess of revenues over expenses, or, in the case of for-profit entities, net income after tax, as determined in accordance with generally accepted accounting principals, to which shall be added, in either case, (i) depreciation, (ii) amortization, (iii) interest expense on Long-Term Indebtedness (as defined in the Master Indenture) and (iv) to the extent not already included, contributions and donations and from which shall be excluded any extraordinary items, any impairment losses, any gain or loss resulting from either the extinguishment of indebtedness or the sale, exchange or other disposition of assets not made in the ordinary course of business, provided, however, that (a) no determination of Income Available for Debt Service will take into account any gains or losses resulting from the periodic valuation of investments or Hedge Agreements that do not

involve the sale, transfer or other disposition of any such investment or Hedge Agreement or the termination of any Hedge Agreement and (b) a person may include in its net income such person's share of the net income of any person controlled by such person or in whom such person has a legal interest. The Master Indenture contains provisions relating to the calculation of Maximum Annual Debt Service that provides for reallocation of amounts due on balloon indebtedness and assumptions as to the interest rates on variable rate indebtedness and payment of guaranties. For financial information of the Alliance, see Appendix A and the Alliance's audited consolidated financial statements for the fiscal years ended June 30, 2011 and June 30, 2010, included as Appendix B. For a more complete description of the covenants under the Master Indenture, see "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Rates and Charges" in Appendix C.

Only Obligated Issuers are obligated to make payments on the Series 2012A Bonds and to abide by the covenants under the Master Indenture. The audited and unaudited financial statements included as Appendices B and C reflect the assets and operations of entities that are not Obligated Issuers. See Appendix A − "CONDENSED SUMMARY OF REVENUE AND EXPENSES; FINANCIAL STATEMENTS."

Amendment of Master Indenture

By purchasing the Series 2012A Bonds, the initial holders thereof will consent to an amendment to the definition of "Debt Service Requirement" in the Master Indenture and an amendment to the requirements applicable to interest rate swaps. Such amendments will not become effective immediately and will become effective only upon receipt of the consent of the required percentage of bondholders and credit enhancers under the terms of the Master Indenture.

Both the existing definition and the proposed definition are set forth in Appendix C, "SUMMARY OF THE FINANCING DOCUMENTS – DEFINITIONS OF CERTAIN TERMS." The definition of "Debt Service Requirement" is utilized in calculations under both the additional debt test and the rate covenant under the Master Indenture, and such amendment may in certain circumstances increase or decrease the amount of the Debt Service Requirement in any required calculation. See "Additional Long-Term Indebtedness" and "Rates and Charges" in "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE" in Appendix C.

Both the existing requirements and the proposed new requirements for interest rate swaps are set forth in Appendix C.

Pledged Assets; Mortgage

Currently, the Series 2012A Bonds are secured by the Trust Estate, including the assignment of the Series 2012A Obligation. As security for its Master Obligations, the Alliance has granted to the Master Trustee a security interest in its Pledged Assets, subject to Permitted Liens. The Pledged Assets consist of: Receivables, Inventory, Equipment, General Intangibles, Contracts and Contract Rights, Government Approvals, Fixtures and other personal property, goods, instruments, chattel paper, documents, credits, claims, demands and assets. For a definition of these terms see Appendix C - "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS." Financing statements will be filed in the appropriate records of the Office of the Tennessee Secretary of State to perfect the security interest in Pledged Assets and Equipment to the extent possible by such filing. Continuation statements meeting the requirements of the Uniform Commercial Code of Tennessee (the "UCC") must be filed every five years to continue the perfection of such security interest. The security interest in the Pledged Assets and Equipment is subject to Permitted Liens that exist prior to or may be created subsequent to the time the security interest granted by the Master Indenture attaches.

The security interest in any item of inventory will be inferior to the interest of a buyer in the ordinary course of business and will be inferior to a purchase money security interest, as defined in the UCC, perfected in connection with the sale to an Obligated Issuer of such item. The lien on certain other Pledged Assets may not be enforceable against third parties unless such other Pledged Assets are transferred to the Master Trustee (which transfer Obligated Issuers are not required by the Master Indenture to make prior to an Event of Default thereunder and which transfer may be set aside if it occurs within 90 days of the filing of a petition in bankruptcy) and is subject

to exception under the UCC. The federal government may in the future proscribe or restrict the assignment of rights arising out of Medicare, Medicaid or other federal programs.

As a condition to becoming a Member of the Obligated Group, an entity must grant to the Master Trustee a security interest in its Pledged Assets.

Pursuant to the Master Indenture, the Obligated Issuers agree that they will not create or suffer to be created or exist any Lien other than Permitted Liens, as defined under "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS" in Appendix C, upon any of their facilities now owned or hereafter acquired.

The Series 2012A Obligation is also secured by a mortgage on the Johnson City Medical Center located in Johnson City, Tennessee, and the Sycamore Shoals Hospital facility in Elizabethton, Tennessee (together, the "Mortgaged Property"). Such mortgage secures all Master Obligations issued under the Master Indenture.

Subject to certain conditions, in case of the failure of the Obligated Issuers to make any payment on the Master Obligations when due or upon any other event of default under the Master Indenture, the Master Trustee may, after such notice as is required by the Master Indenture and the applicable security instruments, take possession of Mortgaged Property or, upon such public notice as required by Tennessee statute, sell the Mortgaged Property, and apply the proceeds to payment of principal of and interest on the Master Obligations (and thereby on the Series 2012A Bonds) on a parity basis with any other Master Obligation.

Additional Indebtedness

The Alliance has certain debt outstanding under the Master Indenture. The Master Indenture permits the Alliance and any other members of the Obligated Group to incur Additional Indebtedness (including Guaranties), all upon the terms and subject to the conditions specified therein. Such Additional Indebtedness may, but need not, be evidenced or secured by a Master Obligation. Additional Indebtedness may be issued to the Issuer or to persons other than the Issuer.

The reimbursement obligations of the Alliance with respect to the Letters of Credit will also be secured under the Master Indenture.

Except as noted in the preceding paragraph, the Master Indenture, the Alliance and each other Obligated Issuer agrees that it will not incur other Additional Indebtedness unless it can demonstrate that certain coverage ratios have been and will be met between debt service obligations and Income Available for Debt Service. Under the Master Indenture, Additional Indebtedness may be Long-Term Indebtedness or Short-Term Indebtedness. The Master Indenture allows any future Obligated Issuer to incur Additional Indebtedness under the Master Indenture as a Master Obligation constituting the joint and several obligation of the Alliance and all other Obligated Issuers and subject to cross-guarantees of all Obligated Issuers, including the Alliance. Except to the extent entitled to the benefits of additional security as permitted by the Master Indenture and except for Subordinated Indebtedness, all Master Obligations will be equally and ratably secured by the Master Indenture. See Appendix C - "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE."

Subject to certain conditions set forth in the Master Indenture, Additional Indebtedness incurred by any Member of the Obligated Group may be secured by security which does not extend to any other Indebtedness. Such security may include Liens on the Property (including health care facilities) of the Members of the Obligated Group, letters or lines of credit or insurance, and could also consist of Liens on cash or securities deposited or held in any depreciation reserve, debt service or interest reserve, debt service or similar fund established pursuant to the terms of any Supplemental Master Indenture, Related Bond Indenture or Related Loan Document. The Master Indenture provides that Supplemental Master Indentures pursuant to which one or more series of Master Obligations entitled to additional security are issued may provide for such amendments to provisions of the Master Indenture, including the provisions thereof relating to the exercise of remedies upon the occurrence of an event of default, as are necessary to

provide for such security and to permit realization upon such security solely for the benefit of the Master Obligation secured thereby.

Defeasance

If the interest on, and the principal or redemption price (as the case may be) of the Series 2012A Bonds have been paid, or the required amount of money and/or Defeasance Investment (see "SUMMARY OF THE FINANCING DOCUMENTS - DEFINITIONS OF CERTAIN TERMS" in Appendix C) have been deposited with the Bond Trustee to provide sufficient amounts to pay the principal of, and premium, if any, and interest due and to become due on such Series 2012A Bonds on or prior to the redemption date or maturity date thereof, such Series 2012A Bonds shall no longer be deemed outstanding under the Bond Indenture and will no longer be secured thereby. If all Series 2012A Bonds have been so provided for, the Bond Trustee shall cancel and discharge the Bond Indenture. See "SUMMARY OF THE FINANCING DOCUMENTS - SUMMARY OF CERTAIN PROVISIONS OF THE BOND INDENTURE - Defeasance" in Appendix C.

Bankruptcy

The lien on the Pledged Assets and Equipment given for the benefit of holders of Master Obligations (and thereby the Series 2012A Bonds) are generally superior to the claims of other creditors (subject to the limitations set forth above). However, bankruptcy and similar proceedings and usual equity principles may affect the enforcement of rights to such security. If such security is inadequate for payment in full of the Bonds, bankruptcy proceedings and usual equity principles may also limit any attempt by the Master Trustee to seek payment from other property of the Alliance or future Obligated Issuers. In particular, federal bankruptcy law permits adoption of a reorganization plan even though it has not been accepted by the holders of a majority in aggregate principal amount of the Bonds if the holders are provided with the benefit of their original lien or the "indubitable equivalent." In addition, if the bankruptcy court concludes that the holders have "adequate protection," it may (1) substitute other security for the security subject to the lien of the holders and (2) subordinate the lien of the holders to claims by entities or persons supplying post petition financing to the Alliance after bankruptcy. Furthermore, the reasonable and necessary costs and expenses of preserving or disposing of the Pledged Assets and Equipment in a bankruptcy may, in certain circumstances, reduce the value of the lien on the Pledged Assets and Equipment to the extent such costs and expenses benefit the Master Trustee (and holders). In the event of the bankruptcy of the Alliance, the amount realized by the holders might depend on the bankruptcy court's interpretation of "indubitable equivalent" and "adequate protection" under the then existing circumstances, which may result in a reduction in the security for or proceeds available to the holders.

INTEREST RATE SWAPS

The Alliance has various interest rate swaps and related derivatives currently in place, as described in Appendix A. Some of the existing arrangements have been entered into with affiliates of the Underwriter. The Alliance may in the future enter into swap agreements with respect to some or all of its obligations issued under the Master Indenture. See "MANAGEMENT'S DISCUSSION OF FINANCIAL PERFORMANCE − Interest Rate Swaps and Derivatives" in Appendix A.

CERTAIN RISK FACTORS

The purchase of the Series 2012A Bonds involves certain risks that are discussed throughout this Official Statement. Each prospective purchaser of the Series 2012A Bonds should make an independent evaluation of all of the information presented in this Official Statement in order to make an informed investment decision. Certain of these risks are described below.

General

The ability of the Obligated Issuers to make payments on the Series 2012A Bonds is dependent upon the ability of the Obligated Issuers to generate revenue sufficient to cover collective operating expenses and debt service on the Series 2012A Bonds and other indebtedness of the Obligated Issuers. Health care providers, especially

hospitals, face increasing economic pressures from both governmental health care programs and private purchasers of health care such as insurance companies and health maintenance organizations (collectively, "third-party payors"). The dependence of hospitals on governmental programs requires hospitals to accept both limitations on payments and regulations and other restrictions and requirements triggered by participation in such programs. Many governmental and private third-party payors have required healthcare providers to accept "capitated" or other fixed payments, which have the affect of shifting significant economic risk to healthcare providers.

Health care, especially at the hospital level, is a highly regulated industry with complicated and frequently changing regulations arising both from payment programs and governmental police power generally. Health care providers are increasingly subject to audits, investigations, fines and litigation that may threaten access to governmental reimbursement programs, require substantial payments, generate adverse publicity and create significant legal and other transaction costs. See below "Health Care Revenues." In addition, because the Alliance and a number of its affiliates are tax-exempt charitable organizations under the Internal Revenue Code ("Exempt Organizations"), they are subject to increasing regulation and restrictions that may have adverse effects on their economic performance or threaten their tax-exempt status and the economic benefits derived from it. In particular, such regulations and restrictions may require the facilities of the Alliance or such affiliates to provide health care services for which they do not receive payment. In addition, Congress is likely to consider imposing additional regulations and restrictions on Exempt Organizations.

Future economic and other conditions, including inflation, demand for health care services, the ability of the Alliance and other members of the Obligated Group to provide the services required or requested by patients, physicians' confidence in the Alliance, economic developments in the applicable service areas, employee relations and unionization, competition, the level of rates or charges, increased costs, availability of professional liability insurance, casualty losses, third-party reimbursement and changes in governmental regulation may adversely affect revenues and, consequently, the ability of the Alliance and other members of the Obligated Group to generate revenues sufficient for the payment of the principal of and interest on the Series 2012A Obligation.

Certain more specific factors that could affect the Series 2012A Bonds and the future financial condition of the Alliance and any future members of the Obligated Group are described below. This discussion of risk factors is not intended to be exhaustive.

Discretion of the Board and Management

The Master Indenture does not significantly restrict the ability of the Alliance to enter into transactions that could materially affect the business, organizational structure and control of the Alliance and any future members of the Obligated Group. Such transactions could include, for example, such things as divestitures of Affiliates, substantial new joint ventures, and mergers, consolidations or other forms of affiliations in which control of the Alliance and any future members of the Obligated Group could be materially changed. As a substantial health system, the Alliance regularly considers and analyzes opportunities for such undertakings. The ability of the Alliance to generate revenues sufficient to pay debt service on the Series 2012A Obligation is dependent in large measure on the decisions of the Board of Directors and management of the Alliance with respect to such opportunities.

Voting Control Under Master Indenture

Certain amendments and waivers to the provisions of the Master Indenture may be made with the consent of the owners of 75% of the aggregate principal amount of the Master Obligations then outstanding. Certain other amendments may be made with the consent of the owners of two-thirds (2/3) in aggregate principal amount of Master Obligations related to bonds that are not the beneficiaries of certain municipal bond insurance policies and the consent of the provider of certain municipal bond insurance policies. Such amendments may adversely affect the security of the holders of the Series 2012A Bonds.

For a discussion of what actions may be taken with the consent or direction of a majority percent or more of the holders of outstanding Master Obligations under the Master Indenture, see the discussion under "SUMMARY OF THE FINANCING DOCUMENTS" in Appendix C.

Matters Relating to Enforceability of the Master Indenture

The practical realization of any rights upon any default under the Loan Agreement or under the Master Indenture may depend upon the exercise of various remedies specified in such instruments, as restricted by federal and state laws. The federal bankruptcy laws may adversely affect the ability of the Bond Trustee, the Master Trustee and the owners of the Series 2012A Bonds to enforce their claims granted by the Bond Indenture, the Loan Agreement or the Master Indenture. The obligation of the Alliance on the Series 2012A Obligation and other Master Obligations will be limited to the same extent as the obligations of debtors typically are affected by bankruptcy, reorganization, insolvency, fraudulent conveyance, moratorium or other similar laws affecting the enforcement of creditors' rights and by the availability of equitable remedies.

The remedies available to the Bond Trustee, the Master Trustee, the Issuer or the owners of the Series 2012A Bonds upon an event of default under the Master Indenture, the Bond Indenture, the Loan Agreement or the Series 2012A Obligation are in many respects dependent upon judicial actions, which are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including, specifically, Title 11 of the United States Code (the "Bankruptcy Code"), the remedies provided in the Master Indenture, the Bond Indenture, the Loan Agreement and the Series 2012A Obligation and other Master Obligations may not be readily available or may be limited.

There is no clear precedent in the law as to whether transfers from an Affiliate in order to pay debt service on the Master Obligations issued for the benefit of another Affiliate may be voided by a trustee in bankruptcy in the event of a bankruptcy of the transferring Affiliate or by third-party creditors in an action brought pursuant to state fraudulent conveyances statutes. Under the United States Bankruptcy Code, a trustee in bankruptcy and, under state fraudulent conveyances statutes, a creditor of a related guarantor, may avoid any obligation incurred by a related guarantor, if, among other bases therefor, (i) the guarantor has not received fair consideration or reasonably equivalent value in exchange for the guaranty and (ii) the guaranty renders the guarantor insolvent, as defined in the United States Bankruptcy Code or state fraudulent conveyances statutes, or the guarantor is undercapitalized.

Limited Value at Foreclosure

The Mortgaged Property was constructed for the provision of hospital care. The number of entities that could be expected to purchase or lease the Mortgaged Property are limited, and thus, the ability of the Master Trustee to realize funds from the sale or rental of the Mortgaged Property upon an event of default may be limited.

Bond Ratings

There is no assurance that the ratings assigned to the Series 2012A Bonds will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for and marketability of the Series 2012A Bonds. See "RATINGS."

Market for the Series 2012A Bonds

The relative buying and selling interest of market participants in securities such as the Series 2012A Bonds, and in the market for such securities as a whole, will vary over time, and such variations may be affected by, among other things, news relating to the Alliance and the other Obligated Issuers, the attractiveness of alternative investments, the perceived risk of owning the security (whether related to credit, liquidity or any other risk), the tax treatment accorded the instruments, the accounting treatment accorded such securities, reactions to regulatory actions or press reports, financial reporting cycles and marketing sentiment generally. Shifts of demand in response to any one or simultaneous particular events cannot be predicted and may be short-lived or exist for longer periods. See below "Matters Affecting Tax Exemption."

Health Care Revenues

There are a number of factors that could adversely affect both revenues and expenses of the Alliance. Some but not all such factors are discussed briefly below. Governmental payment provisions, regulations and other restrictions change frequently and may be altered or expanded while the Series 2012A Bonds are outstanding.

Dependence on Governmental and Other Third-Party Payors. The Alliance receives a substantial portion of its revenues from Medicare, Medicaid, TennCare and other third-party health care programs. See in Appendix A - "SOURCES OF REVENUE." Receipt of such revenues subjects the Alliance to extensive regulation and the risks of enforcement as described below. Both governmental payment programs and private third-party payors such as insurance and managed care programs have increasingly imposed limitations on the payment for services. These limitations often require hospitals to provide certain services below cost. Congress in the past has imposed substantial restrictions on federal health care programs that have adversely affected the financial condition of hospitals, and it may do so in the future.

TennCare. In 1994, the State of Tennessee, with the approval of the federal government, withdrew from the Medicaid program and began providing services to Medicaid eligible and uninsurable or uninsured persons through TennCare. Like traditional Medicaid programs, TennCare is funded with a combination of federal and State of Tennessee funds. The federal government has approved the TennCare Program through June 30, 2010. The Alliance is a significant provider of health care services to TennCare enrollees and as a result thereof has incurred substantial losses serving beneficiaries of the program. Approximately 8.3% of the Alliance's gross patient service charges for the fiscal year ended June 30, 2011, was derived from patients covered by TennCare.

Because of problems with managed care organizations through which TennCare operates, the State assumed total medical risk for the program in 2002 and implemented changes designed to reduce costs and fraud. The State of Tennessee initiated a plan to disenroll 323,000 individuals statewide from TennCare and to institute significant benefit cuts resulting in the disenrollment of 28,000 individuals in the Alliance's market and a decrease in the level of benefits for 40,000 individuals in the Alliance's market. The disenrollment changes took place on August 1, 2005, however, the benefit cuts have not been implemented.

On April 1, 2007, the State of Tennessee began placing the managed care organizations back at risk, starting with the Middle Tennessee Region. The State of Tennessee placed the East Tennessee Region's managed care organizations (where the Alliance operates its Tennessee facilities) back at risk on January 1, 2009. It cannot be predicted whether the funding sources for TennCare or other states' Medicaid programs will be adequate to meet the funding needs of such programs. In addition, it cannot be predicted whether funding pressures or other factors will lead to decreased TennCare and Medicaid reimbursement to providers, including the Members of the Obligated Group, or to an increase in uninsured patients seeking care from the Members of the Obligated Group.

A number of proposals have been made for changes in funding for TennCare, some of which could substantially reduce the amounts payable to the Alliance's facilities in Tennessee. There remains substantial risk that TennCare will continue to impose substantial financial burdens on the Alliance or that changes in the program could lead to further burdens or increase the cost of uncompensated care provided by the Alliance.

Virginia Medicaid Program. The hospitals of the Alliance located in Virginia receive a substantial portion of their revenues under the federal Medicare Program. Reimbursement under this program is controlled by extensive regulations and procedures. Under the current Medicare payment system payment for inpatient hospital services is been tied to predetermined amounts based on national averages of costs for categories of treatments and conditions known as diagnosis related groups ("DRGs"). DRG reimbursement may provide a hospital less than its actual costs in providing services. The Medicare Program reimburses for outpatient hospital services through a similar prospective payment system based on ambulatory payment classifications ("APCs") of clinically-related and resource-similar items and services. Reimbursement for outpatient services under the APC system and for other services provided by the hospitals of the Alliance may not reflect the actual costs incurred in providing such services or items.

Medicare reimbursement in recent years has been subject to changes that have adversely affected hospitals, and the Alliance cannot predict how future limitations, cutbacks or modifications by Congress or regulatory agencies to such reimbursement may affect the financial condition of the Alliance.

Hospital Regulation. The operation of hospitals is extensively regulated by the federal and state governments. These regulations affect virtually every aspect of hospital operations, including (1) imposing procedures that increase costs (including complicated billing and other record-keeping procedures), (2) requiring the provision of services free or below cost, (3) limiting the ability to make decisions based on economic best interest and (4) restricting the ability to pursue advantageous business opportunities with physicians and other health care providers.

Significant restrictions include (1) the Physicians Self-Referral ("Stark") and "Anti-Kickback" laws, which severely restrict financial relationships with and referrals by private physicians; (2) the Emergency Medical Treatment and Active Labor Act ("EMTALA"), imposing operating requirements on emergency rooms; and (3) the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act of 2009 and both affecting the privacy and security of personal health information. Compliance with HIPAA, HITECH and related regulations has imposed substantial financial burdens on the Alliance and related entities in such areas as electronic billing and other electronic transactions and in implementing procedures and altering facilities to promote privacy of patient records.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate violations of existing laws and regulations, including criminal fines, civil monetary penalties, repayment of erroneously paid claims, prison terms and exclusion from the Medicare, Medicaid, TennCare and/or other governmental payment programs. Because of the complexity of the regulations and the increased enforcement, there are numerous circumstances where alleged violations may trigger investigations, audits and inquiries that could result in expensive and prolonged enforcement actions against the Alliance. Enforcement actions may be initiated and prosecuted by one or more government entities and/or private individuals, and in some circumstances more than one of the available penalties may be imposed for each violation. An exclusion from participation in Medicare, Medicaid, TennCare or other governmental health programs likely would result in a loss of substantial revenues.

National Healthcare Reform

Comprehensive health care reform legislation was enacted by the federal government in March 2010 through the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Healthcare Reform Act"). The Healthcare Reform Act provides for fundamental changes to the health care system and the manner in which services are provided and paid for generally, including substantial increases in health care insurance for persons not currently covered, new requirements on employers who provide health benefits to their employees, reimbursement reductions and methodology changes, and the imposition of further restrictions and requirements adversely affecting tax-exempt hospitals such as the Alliance and its related entities.

Implementation of the Healthcare Reform Act is to take place over an eight year period, and over that time the Healthcare Reform Act is likely to have a variety of effects on both the operations and financial performance of all hospitals. In particular, extension of health insurance to those not currently insured and the costs associated therewith may result in (1) inadequate reimbursement to cover costs under such new coverage, (2) offsetting reductions in reimbursements for the provision of services under Medicare, Medicaid and other federally funded programs and (3) increased costs of compliance generally. In addition, the Healthcare Reform Act is likely to have significant indirect effects on the Alliance and related hospitals as a result of the Act's effects on other healthcare industry participants, including pharmaceutical and medical device companies, health insurers, and others with which the Alliance and related hospitals do business.

The Healthcare Reform Act imposes substantial and costly additional requirements on nonprofit hospitals. Failure of any hospital with 501(c)(3) status to comply with such requirements may result in significant penalties

including, but not limited to, the loss of tax-exempt status. See below "Matters Affecting Tax Exemption − Tax Exemption for Non-profit Corporations."

The United States Supreme Court recently upheld the constitutionality of the Health Care Reform Act. There have been, and will likely continue to be, legislative efforts in Congress to repeal, amend or defund the Healthcare Reform Act or otherwise block its implementation. The outcome of such efforts will be affected by the 2012 Congressional and Presidential elections. Thus it is impossible to predict the extent to which the Healthcare Reform Act will be implemented or the effects it will have to the extent it is implemented.

Competition

The Alliance faces competition not only from other area hospitals (see in Appendix A -"SERVICE AREA, MARKET SHARE AND COMPETITION"), but also from other forms of health care providers, including health maintenance organizations, preferred provider organizations, specialty hospitals, home health agencies, surgical centers, rehabilitation and therapy centers, physician group practices and other alternative delivery systems and non-hospital providers of medical services. Increasing costs of health care services are likely to stimulate additional forms of competition. Many new forms of health care providers may not be subject to the restrictions imposed on the Alliance by its participation in governmental health care programs and as part of a tax-exempt organization. The application of federal and state antitrust laws to health care is still evolving, and enforcement and other developments in this area could adversely affect the Alliance's competitive position.

Other Economic Developments

Other economic developments that could adversely affect operations at the Alliance include (1) unexpected increases in costs of labor and equipment (including new technologies) that cannot be recovered through charges, (2) increased costs of maintaining malpractice and general liability insurance, and (3) availability of, or the cost of, required specialty employees, including nurses and other health care professionals.

Matters Affecting Tax Exemption

Tax Exemption for Non-profit Corporations. Loss of tax-exempt status by the Alliance could result in loss of tax exemption for interest on the Series 2012A Bonds and of other tax-exempt debt issued for the benefit of the Alliance, and defaults in covenants regarding the Series 2012A Bonds and other tax-exempt debt would likely be triggered. Such an event would have material adverse consequences on the financial condition of the Alliance. See "TAX MATTERS."

The maintenance by the Alliance of its tax-exempt status and that of its related entities depends, in part, upon its maintenance of status as an organization (an "Exempt Organization") described in Section 501(c)(3) of the Code. The maintenance of such status is contingent upon compliance with provisions of the Code and related regulations and administrative interpretations regarding the organization and operation of tax-exempt entities, including its operation for charitable and educational purposes and its avoidance of transactions that may cause its assets to inure to the benefit of private individuals.

The Internal Revenue Service (the "IRS") has announced that it intends to closely scrutinize transactions between Exempt Organizations and for-profit entities and has issued audit guidelines for tax-exempt hospitals. In March 1998, the IRS issued a revenue ruling that places restrictions upon the participation of Exempt Organizations (including hospitals) in joint venture arrangements with for-profit entities. Although specific activities of hospitals, such as medical office building leases and compensation arrangements and other contracts with physicians, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities have not been addressed in any official opinion, interpretation or policy of the IRS. Because the Alliance conducts large-scale and diverse operations involving private parties, there can be no assurances that certain of its transactions would not be challenged by the IRS.

The IRS has taken the position that hospitals that violate the federal Anti-kickback Law may also be subject to revocation of their tax-exempt status. As a result, tax-exempt hospitals, such as those of the Alliance, which have