Exhibit 11.5

Attachment A

Wellmont 2011 Bonds Official Statement for 2011 Bonds

NEW ISSUE – BOOK ENTRY ONLY **RATINGS: See "RATINGS" herein**

$76,165,000
THE HEALTH, EDUCATIONAL AND HOUSING FACILITIES BOARD OF THE COUNTY OF SULLIVAN, TENNESSEE
Hospital Revenue Refunding Bonds (Wellmont Health System Project), Series 2011

Bond Issuer. The Bonds are being issued by The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the "Issuer").

Beneficiary of Financing. The Bonds are being issued to provide financing for the benefit of Wellmont Health System (the "Corporation").

Wellmont Health System

Purpose of Financing. The Bonds will be issued for the purpose of refunding bonds previously issued to provide financing for the benefit of the Corporation. See "THE FINANCING PLAN".

Financing Documents. The Bonds are being issued pursuant to a Bond Trust Indenture dated as of May 1, 2011 (the "Indenture") between the Issuer and The Bank of New York Mellon Trust Company, N.A., as trustee (the "Trustee"). Proceeds of the Bonds will be loaned to the Corporation pursuant to a Loan Agreement dated as of May 1, 2011 (the "Loan Agreement") between the Issuer and the Corporation. The loan repayment obligation of the Corporation will be evidenced and secured by a promissory note (the "Series 2011 Obligation") issued by the Corporation as an obligation under the Master Indenture described herein.

Source of Payment and Security. The Bonds will be limited obligations of the Issuer payable solely out of payments by the Corporation pursuant to the Loan Agreement and payments by the Obligated Group pursuant to the Series 2011 Obligation. Payment of the Bonds is secured by the trust estate established under the Indenture, which includes (i) rights of the Issuer under the Loan Agreement and the Series 2011 Obligation, and (ii) money in the funds and accounts established under the Indenture. The Series 2011 Obligation and all other obligations issued under the Master Indenture will be secured by a pledge and assignment of gross receipts of the Obligated Group and a mortgage on certain operating assets of the Obligated Group. See "SOURCE OF PAYMENT AND SECURITY".

The Bonds will not be general or full faith and credit obligations of the Issuer. The Bonds will be limited obligations of the Issuer payable solely out of the sources identified in the Indenture. Neither the State of Tennessee nor any of its political subdivisions, agencies or instrumentalities (including without limitation Sullivan County, Tennessee) is liable in any way for payment of the Bonds.

Pricing Terms and Payment Dates. Pricing information for the Bonds, including principal maturities, interest rates, payment dates and authorized denominations, is shown on the inside cover of this Official Statement.

Form and Date of Delivery. The Bonds are being issued under the book entry system maintained by The Depository Trust Company ("DTC"). The Bonds are expected to be delivered on May 5, 2011.

Redemption. The Bonds are subject to redemption prior to maturity as herein described.

Legal Opinions. McGuireWoods LLP, Richmond, Virginia, has served as bond counsel and will deliver its opinion with respect to the Bonds in substantially the form attached as APPENDIX D. In connection with the issuance of the Bonds, Penn, Stuart & Eskridge, A Professional Corporation, Bristol, Tennessee, has served as counsel to the Issuer, Hunter, Smith & Davis, LLP, Kingsport, Tennessee, has served as counsel to the Corporation and the Obligated Group, and Presley Burton & Collier, LLC, Birmingham, Alabama, has served as counsel to the Underwriter.

Tax Status. In the opinion of Bond Counsel, under existing law and subject to conditions described in the sections herein entitled "TAX STATUS" (1) interest on the Bonds is excludable from gross income for federal income tax purposes under Section 103 of the Internal Revenue Code of 1986, as amended (the "Code"), (2) interest on the Bonds is not treated as a preference item in calculating the alternative minimum tax imposed under the Code with respect to individuals and corporations, and (3) interest on the Bonds will be included in the adjusted current earnings of certain corporations for purposes of computing the alternative minimum tax imposed thereon. In the opinion of Bond Counsel, under the existing laws of the State of Tennessee, the Bonds and the interest thereon are exempt from all State of Tennessee state, county and municipal taxation except for inheritance, transfer and estate taxes and except to the extent that the Bonds and the interest thereon are included within the measure of certain privilege and excise taxes imposed under Tennessee law. See the section herein entitled "TAX STATUS."

Risk Factors. For a description of certain risk factors involved in an investment in the Bonds, see "RISK FACTORS".

Underwriter. The Bonds are being purchased from the Issuer by the following underwriter:

BofA Merrill Lynch

The date of this Official Statement is May 2, 2011.

$76,165,000
The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee
Hospital Revenue Refunding Bonds
(Wellmont Health System Project),
Series 2011

PRICING INFORMATION

$76,165,000 Term Bonds

Maturity (September 1)	Principal Amount	Interest Rate	Price	Yield	Initial CUSIP Number
2026	$42,385,000	6.00%	100.00%	6.00%	865293 AG9
2032	33,780,000	6.50%	100.00%	6.50%	865293 AH7

Date of Bonds. The Bonds will be dated as of the date of their initial delivery. There will be no accrued interest payable as part of the initial offering price.

Authorized Denominations. The Bonds may be issued in denominations of $5,000 or any integral multiple thereof.

Interest Payment Dates. Interest on the Bonds is payable on March 1 and September 1 of each year, beginning September 1, 2011.

Principal Payment Dates. The Bonds mature on September 1 in years and amounts as shown above.

Redemption Prior to Maturity. The Bonds are subject to redemption prior to maturity as described herein. See "THE BONDS—Redemption Prior to Maturity."

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OFFICIAL STATEMENT

Regarding

$76,165,000
The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee
Hospital Revenue Refunding Bonds
(Wellmont Health System Project), Series 2011

INTRODUCTION

This Official Statement provides information for use in connection with the offering by The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the "Issuer") of its $76,165,000 Hospital Revenue Refunding Bonds (Wellmont Health System Project), Series 2011 (the "Bonds"). The Issuer is a public corporation organized under the laws of the State of Tennessee. The Bonds will be issued pursuant to a Bond Trust Indenture dated as of May 1, 2011 (the "Indenture") between the Issuer and The Bank of New York Mellon Trust Company, N.A., as trustee (in such capacity, the "Trustee").

The Bonds will be issued to provide financing for the benefit of Wellmont Health System, a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code (the "Corporation"). The Corporation is headquartered in Kingsport, Tennessee and operates a health care delivery system that includes six acute care hospitals and one critical access hospital that serve northeast Tennessee and southwest Virginia.

The Bonds are being issued for the purpose of refunding bonds previously issued to provide financing for the benefit of the Corporation. Proceeds of the Bonds will also be used to pay costs incurred in connection with the issuance of the Bonds. See "THE FINANCING PLAN".

The proceeds of the Bonds will be loaned by the Issuer to the Corporation pursuant to a Loan Agreement dated as of May 1, 2011 (the "Loan Agreement") between the Issuer and the Corporation. Pursuant to the Loan Agreement the Corporation will agree to make payments at times and in amounts sufficient to pay debt service on the Bonds. The Corporation's loan repayment obligation will be evidenced by a promissory note issued as an obligation (the "Series 2011 Obligation") under the Master Indenture described below.

The Corporation and certain of its affiliates have entered into a Master Trust Indenture dated as of May 1, 1991, as amended (the "Master Indenture"), with U.S. Bank National Association (as successor to Wachovia Bank, National Association, First Union National Bank, and Dominion Bank of Middle Tennessee), as trustee (the "Master Trustee"). The Corporation and its affiliates that have joined in the execution and delivery of the Master Indenture are referred to in the Master Indenture and this Official Statement as the "Obligated Group". The Corporation, Wellmont, Inc. ("Wellmont"), Wellmont Foundation ("Wellmont Foundation") and Wellmont Hawkins County Memorial Hospital, Inc. ("Wellmont Hawkins") are currently the only members of the Obligated Group. See APPENDIX A for information about the current members of the Obligated Group. Members of the Obligated Group are jointly and severally liable for payment of the obligations issued under the Master Indenture (the "Master Indenture Obligations"). The Master Indenture permits the addition and withdrawal of members of the Obligated Group. Pursuant to the Loan Agreement, the Corporation will covenant not to withdraw from the Obligated Group as long as any Bonds remain outstanding. See APPENDIX C for the pertinent provisions of the Master Indenture. Pursuant to the Master Indenture the Obligated Group has pledged and assigned its gross receipts as security for all Master Indenture Obligations. The Obligated Group has also entered into separate deeds of trust (the "Deeds of Trust") in the State of Tennessee and the Commonwealth of Virginia in favor of the Master Trustee that create a mortgage lien on certain operating assets of the Obligated Group. The Master Indenture and the Deeds of Trust are for the equal and proportionate benefit and security of all Obligations issued under the Master Indenture. See "SOURCE OF PAYMENT AND SECURITY—The Master Indenture".

The Bonds will be limited obligations of the Issuer payable solely out of payments by the Corporation pursuant to the Loan Agreement and payments by the Obligated Group pursuant to the Series 2011 Obligation.

The Bonds will not be general or full faith and credit obligations of the Issuer. The Bonds will be limited obligations of the Issuer payable solely out of the sources identified in the Indenture. Neither the State of Tennessee nor any of its political subdivisions, agencies or instrumentalities (including without limitation Sullivan County, Tennessee) is liable in any way for payment of the Bonds.

The Indenture will establish a trust estate (the "Trust Estate") that will be pledged and assigned to the Trustee. The Trust Estate includes (i) the Issuer's rights under the Loan Agreement and the Series 2011 Obligation, and (ii) money in the funds and accounts established under the Indenture. The Trust Estate will be held by the Trustee for the equal and proportionate benefit of the holders of the Bonds. See "SOURCE OF PAYMENT AND SECURITY—Trust Estate Created by the Indenture".

Investment in the Bonds involves a certain degree of risk. See "RISK FACTORS" for a description of those risks.

DEFINITIONS

This section contains the definition of terms frequently used in this Official Statement.

"**Act**" means Sections 48-101-301 to 48-101-318, inclusive, Tennessee Code Annotated, as amended.

"**Authorized Denominations**" means denominations of $5,000 and any integral multiple thereof.

"**Bonds**" means the bonds offered by this Official Statement.

"**Book Entry System**" means the book entry system maintained by DTC for the registration, transfer, exchange and payment of debt obligations.

"**Business Day**" means any day other than (a) a Saturday or Sunday, (b) a day on which the Bond Trustee is required or permitted by law to close, and (c) a day on which the New York Stock Exchange is closed.

"**Corporation**" means Wellmont Health System, a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code. The Bonds are being issued to provide financing for the benefit of the Corporation.

"**Deeds of Trust**" means the Tennessee Deed of Trust and the Virginia Deed of Trust.

"**DTC**" means The Depository Trust Company.

"**Financing Documents**" means the Indenture, the Loan Agreement, the Master Indenture, the Series 2011 Obligation and the Deeds of Trust.

"**Gross Receipts**" means the receipts, revenues and other income pledged and assigned by the Obligated Group pursuant to the Master Indenture. See "SOURCE OF PAYMENT AND SECURITY—The Master Indenture" and the definition of Gross Receipts in APPENDIX C – "SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF THE MASTER INDENTURE".

"**Indenture**" means the Bond Trust Indenture dated as of May 1, 2011 between the Issuer and the Trustee.

"**Indenture Funds**" means any fund or account established pursuant to the Indenture. See "SOURCE OF PAYMENT AND SECURITY—Pledge Under Indenture".

"**Issuer**" means The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, a Tennessee public corporation. The Issuer is the issuer of the Bonds.

"**Loan Agreement**" means the Loan Agreement dated as of May 1, 2011 between the Issuer and the Corporation.

"**Master Indenture**" means the Master Trust Indenture dated as of May 1, 1991, as amended and supplemented, and as further supplemented in connection with the issuance of the Bonds, between the members of the Obligated Group and the Master Trustee.

"**Master Indenture Obligations**" means all obligations issued under the Master Indenture, including the Series 2011 Obligation being issued as evidence and security for the loan repayment obligation of the Corporation.

"**Master Trustee**" means U.S. Bank, National Association (as successor to Wachovia Bank, National Association, First Union National Bank and Dominion Bank of Middle Tennessee), as trustee under the Master Indenture.

"**Mortgaged Facilities**" means property subject to the liens of the Deeds of Trust.

"**Obligated Group**" means the Corporation and the affiliates of the Corporation that have joined in the execution and delivery of the Master Indenture. The current members of the Obligated Group are the Corporation, Wellmont, Wellmont Foundation and Wellmont Hawkins. The Master Indenture permits the addition and withdrawal of members of the Obligated Group. See APPENDIX C for the pertinent provisions of the Master Indenture.

"**Series 2006A Bonds**" means the bonds previously issued to provide financing for the benefit of the Corporation that are being refunded through the issuance of the Bonds. See "THE FINANCING PLAN" herein.

"**Series 2011 Obligation**" means the Master Indenture Obligation being issued as evidence of and security for the Corporation's loan repayment obligation with respect to the Bonds.

"**Tennessee Deed of Trust**" means collectively:

(A) Deed of Trust, Security Agreement and Fixture Filing dated as of March 1, 2002, from Wellmont Health System and Kingsport Medical Center, Inc., to Jack W. Hyder, Jr., Trustee, filed for record on March 28, 2002, at 8:00 a.m. in Deed Book 1749C, page 738, securing First Union National Bank, as Master Trustee, and BNY Trust Company of Missouri, as Trustee, the sum of $244,030,000.00 as amended by (i) First Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of February 1, 2003, filed for record on Book 1947C, page 148, said Register's Office, (ii) Second Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of December 1, 2005, filed for record on Book 2342C, page 154, (iii) Third Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of June 1, 2006, filed for record on Book 2416C, page 0378, (iv) Fourth Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of November 1, 2006, filed for record on Book 2466C, page 289, said Register's Office, (v) Fifth Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of July 1, 2007, filed for record on Book 2567C, page 695, said Register's Office, and (vi) Sixth Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of November 1, 2010, filed of record in Book 2924C, page 455, said Register's Office;

(B) Deed of Trust, Security Agreement and Fixture Filing dated as of August 1, 2009, of record in Book 2807C, page 174, Office of the Register of Deeds for Sullivan County at Blountville, Tennessee, as amended by First Amendment to Deed of Trust, Security Agreement and Fixture Filing dated as of November 1, 2010, filed of record in Book 2924C, page 471, said Register's Office; and

(C) Leasehold Deed of Trust, Security Agreement and Fixture Filing dated as of August 1, 2009, of record in Book 2807C, page 205, Office of the Register of Deeds for Sullivan County at Blountville, Tennessee, as amended by First Amendment to Leasehold Deed of Trust, Security Agreement

and Fixture Filing dated as of November 1, 2010, filed of record in Book 2924C, page 485, said Register's Office.

"**Term Bonds**" means Bonds subject to scheduled mandatory redemption requirements. Term Bonds are identified in the pricing information included on the inside cover of this Official Statement. See "THE BONDS—Redemption Prior to Maturity".

"**Trust Estate**" means the trust estate established under the Indenture.

"**Trustee**" means The Bank of New York Mellon Trust Company, N.A., as trustee under the Indenture.

"**Virginia Deed of Trust**" means collectively:

(A) Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing dated as of July 1, 2007, of record as Instrument No. 200703183, Office of the Circuit Court Clerk for Lee County, Virginia, as amended by First Amendment to Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing dated as of November 1, 2010, of record as Instrument No. 201003584, said Circuit Court Clerk's Office; and

(B) Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing dated as of July 1, 2007, of record as Instrument No. 0708240, Office of the Circuit Court Clerk for Wise County, Virginia, as amended by First Amendment to Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing dated as of November 1, 2010, of record as Instrument No. 1010076, said Circuit Court Clerk's Office.

"**Wellmont**" means Wellmont, Inc., a Tennessee corporation. Wellmont is a member of the Obligated Group under the Master Indenture.

"**Wellmont Foundation**" means Wellmont Foundation, a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code. Wellmont Foundation is a member of the Obligated Group under the Master Indenture.

"**Wellmont Hawkins**" means Wellmont Hawkins County Memorial Hospital, Inc., a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code. Wellmont Hawkins is a member of the Obligated Group under the Master Indenture.

THE BONDS

Date, Form of Bonds and Denominations

The Bonds will be dated as of the date of initial delivery. The Bonds will be issuable only as fully registered bonds in denominations of $5,000 or any multiple thereof.

Book Entry System

The Bonds are being issued in electronic form under the Book Entry System procedures of The Depository Trust Company ("DTC"). While the Bonds are in the Book Entry System, the method and procedures for payment of the Bonds and matters pertaining to transfers and exchanges of the Bonds will be governed by the rules and procedures of the Book Entry System. If the Book Entry System is discontinued, the Indenture contains alternate provisions for the method of payment and for transfers and exchanges. See APPENDIX F for a description of the DTC Book Entry System. See APPENDIX C – "SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF CERTAIN PROVISIONS OF THE 2011 BOND INDENTURE" for a description of applicable Indenture provisions if the Book Entry System is terminated.

Pricing Information

See the pricing terms on the inside cover of this Official Statement for principal maturities, interest rates and payment dates for the Bonds. The Bonds will be subject to redemption prior to maturity. See "THE BONDS– Redemption Prior to Maturity".

Fixed Interest Rates

The Bonds are being issued as fixed rate obligations.

Calculation of Interest Payments

Interest payable on the Bonds will be calculated on the basis of a 360-day year with 12 months of 30 days each.

Redemption Prior to Maturity

The Bonds will be subject to redemption prior to maturity as follows:

(a) ***Optional Redemption.*** The Bonds are subject to redemption prior to maturity by the Issuer at the option of the Corporation, on or after March 1, 2015, in whole or in part at any time, less than all of such Bonds to be selected by lot or in such other manner as the Trustee determines, at the redemption prices of par plus accrued interest to (but not including) the redemption date.

(b) ***Mandatory Bond Sinking Fund Redemption Without Premium***. The Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot, at a redemption price equal to the principal amount thereof, without premium, plus accrued interest to the redemption date, beginning on September 1, 2013 and on each September 1 thereafter in the years and in the principal amounts set forth below:

September 1	**Principal Amount**
2013	$ 865,000
2014	890,000
2015	990,000
2016	1,390,000
2017	1,155,000
2018	1,205,000
2019	1,285,000
2020	5,585,000
2021	5,595,000
2022	5,895,000
2023	4,090,000
2024	4,280,000
2025	4,480,000
2026 (maturity)	4,680,000

The Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot, at a redemption price equal to the principal amount thereof, without premium, plus accrued interest to the redemption date, beginning on September 1, 2027 and on each September 1 thereafter in the years and in the principal amounts set forth below:

September 1	Principal Amount
2027	$ 4,980,000
2028	5,175,000
2029	5,475,000
2030	5,775,000
2031	6,075,000
2032 (maturity)	6,300,000

In the case of any optional or extraordinary redemption or any purchase and cancellation of any term Bonds that are subject to mandatory sinking fund redemption as described above, the Issuer shall receive credit against its required Bond Sinking Fund deposits with respect to Bonds of the same maturity and interest rate as those being redeemed or purchased.

(c) ***Extraordinary Redemption in Whole or in Part Without Premium***. The Bonds are also subject to redemption prior to maturity in the event of damage to or destruction of the Property of any member of the Combined Group or any part thereof or the condemnation of the Facilities or any part thereof, if the Net Proceeds of insurance or condemnation received in connection therewith to the extent that Net Proceeds are not applied either to any lawful purposes of the Combined 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 called for redemption in the events referred to in the preceding sentence of this paragraph, the Bonds will be subject to redemption at any time, in whole or in part, and if in part, the Corporation may decide the order of maturity or portion of each maturity 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 Corporation, the Trustee will redeem Bonds then Outstanding pro rata based on the then Outstanding principal amount in the inverse order of maturity thereof.

Notice of Redemption. While the Bonds are in book-entry form, notice of redemption will be given only to DTC or its nominee. See "THE BONDS—Book Entry System." Notice of the call for redemption will be given by the Trustee by mailing a copy of the redemption notice (a) by first class mail at least 30 days but not more than 60 days prior to the date fixed for redemption to the owner of each Bond to be redeemed in whole or in part at the address shown on the registration books and (b) by registered or certified mail, facsimile (or other electronic means), or overnight delivery service at least 30 days prior to the date fixed for redemption, to certain following registered securities depositories then in the business of holding substantial amounts of bonds of the type comprising the Bonds and to one or more national information services that disseminate notices of redemption of bonds such as the Bonds. No defect in any notice delivered pursuant to clause (b) above nor any failure to give all or any portion of such notice will in any manner defeat the effectiveness of a call for redemption if notice is given as prescribed in clause (a) above. Any notice mailed as described above will be conclusively presumed to have been duly given, whether or not the owner receives the notice. Failure to mail any such notice, or the mailing of defective notice, to any owner will not affect the proceeding for redemption as to any owner to whom proper notice is mailed.

If at the time of mailing of notice of any optional redemption there has not been deposited with the Trustee moneys sufficient to redeem all the Bonds called for such redemption, such notice may state that it is conditional on the deposit of moneys with the Trustee not later than the redemption date, and such notice will be of no effect unless such moneys are so deposited.

Purchase of Bonds in Lieu of Redemption. The Issuer has irrevocably granted to the Corporation the option to purchase at any time, and from time to time, any Bond which is to be redeemed pursuant to the optional redemption provisions described above on the dates of such redemption and at a purchase price equal to the redemption price. To exercise this option, the Corporation must notify the Trustee not less than five Business Days before the proposed redemption date that amounts available to pay the redemption price of such Bonds shall be applied to purchase such Bonds in lieu of redemption. No notice other than the notice of redemption described under "Notice of Redemption" above must be given in connection with any such purchase in lieu of redemption. On the date fixed for redemption, the Trustee will purchase the Bonds to be redeemed in lieu of such redemption and following such purchase, shall cause such Bonds to be registered in the name of or upon the direction of the

Corporation and deliver them to or as directed by the Corporation. No purchase of Bonds as described in this paragraph will operate to extinguish the indebtedness of the Issuer evidenced thereby. Bonds purchased in lieu of redemption will continue to bear interest at the interest rate in effect on the date of such purchase in lieu of redemption.

SOURCE OF PAYMENT AND SECURITY

Pledge Under Indenture

Pursuant to the Indenture, to secure the payment of the principal of, premium, if any, and interest on the Bonds, the Issuer grants, assigns, transfers, pledges, sets over and confirms and grants a security interest in the property described below (the "Trust Estate") to the Trustee:

(a) All right, title and interest of the Issuer in and to the Series 2011 Obligation and any additional Obligations pledged under the Indenture and all sums payable in respect of the indebtedness evidenced thereby.

(b) All right, title and interest of the Issuer in and to the Loan Agreement (except for Reserved Rights), including, but not limited to, the present and continuing right to make claim for, collect, receive and receipt for any of the sums, amounts, income, revenues, issues and profits and any other sums of money payable or receivable under the Loan Agreement, to bring actions and proceedings thereunder or for the enforcement thereof, and to do any and all things which the Issuer is or may become entitled to do under the Loan Agreement.

(c) All right, title and interest of the Issuer in moneys and securities from time to time held by the Trustee under the terms of the Indenture, other than moneys held in the Rebate Fund.

(d) Any and all other property rights and interests of every kind and nature from time to time hereafter by delivery or by writing of any kind granted, bargained, sold, alienated, demised, released, conveyed, assigned, transferred, mortgaged, pledged, hypothecated or otherwise subjected to the Indenture, as and for additional security thereunder, by the Corporation or any other person on its behalf or with its written consent or by the Issuer or any other person on its behalf or with its written consent.

The Bonds are limited obligations of the Issuer and are payable solely from the Trust Estate. The Corporation agrees under the Loan Agreement and in the Series 2011 Obligation to make payments thereunder directly to the Trustee.

Pledge of Gross Receipts

The Series 2011 Obligation, along with all other Obligations issued under the Master Indenture, including but not limited to the Series 2003 Obligation, the Series 2005 Obligation, the Series 2006C Obligation, the Series 2007A Obligation and the Series 2010 Obligation, are secured on a parity by a security interest in all of the right, title and interest of the Obligated Group in and to its Gross Receipts. "Gross Receipts" are defined in the Master Indenture as: all receipts, revenues, income, gifts, donations, contributions, grants, bequests, pledges, chattel paper and instruments, and other monies received by or on behalf of the Obligated Group, including, but without limiting the generality of the foregoing, (i) revenues derived from the ownership or operation of Property including insurance and condemnation proceeds with respect to Property or any portion thereof, and (ii) all rights to receive the same, whether in the form of accounts, accounts receivable, contract rights or other rights and the proceeds of such rights, whether now owned, or held or hereafter coming into existence; provided, however, that (a) gifts, contributions, grants (including Hill-Burton Grants), bequests and pledges heretofore or hereafter made and designated or specified by the granting authority, donor or maker thereof as being for specified purposes (inconsistent with the payment of debt service on Indebtedness) and income derived therefrom to the extent required by such designation or specification, and (b) revenues, receipts and income derived from the ownership and operation of Property which secures Non-Recourse Indebtedness shall be excluded from Gross Receipts. See "SOURCE OF PAYMENT AND SECURITY—The Master Indenture" and APPENDIX C – "SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE."

Deeds of Trust

The Series 2011 Obligation, along with all other Obligations issued under the Master Indenture, including but not limited to the Series 2003 Obligation, the Series 2005 Obligation, the Series 2006C Obligation, the Series 2007A Obligation and the Series 2010 Obligation (collectively, the "Obligations"), are also secured on a parity by the Tennessee Deed of Trust and the Virginia Deed of Trust (collectively, the "Deeds of Trust") which pledge, grant and convey a security interest in certain real estate and the improvements located thereon (the "Mortgaged Facilities") owned by the Corporation, subject to Permitted Liens. The Tennessee Deed of Trust does not encumber all real estate and the improvements located thereon which are owned or leased by the Corporation in the State of Tennessee. The Virginia Deed of Trust does not encumber all real estate and the improvements located thereon which are owned or leased by the Corporation in the Commonwealth of Virginia.

The Mortgaged Facilities that will be subject to the lien of the Tennessee Deed of Trust are the following facilities: Wellmont Bristol Regional Medical Center and Wellmont Holston Valley Regional Medical Center. The Mortgaged Facilities that will be subject to the lien of the Virginia Deed of Trust are the following facilities: Mountain View Regional Medical Center and Lee Regional Medical Center. Only these facilities are subject to the Deeds of Trust, and certain adjacent medical office buildings and other non-hospital facilities not listed here are not subject to the Deeds of Trust. The Corporation and the Obligated Group also own and lease certain undeveloped land and other real property not subject to the Tennessee Deed of Trust or the Virginia Deed of Trust, including two additional hospitals.

Series 2011 Obligation

Payments on the Series 2011 Obligation pledged under the Indenture will be the joint and several obligation of the members of the Obligated Group. Notwithstanding uncertainties as to the enforceability of the covenants of the members of the Obligated Group in the Master Indenture to be jointly and severally liable for each Obligation (as described under "RISK FACTORS—Limitation on Enforcement of Remedies – *Limitations on Joint and Several Liability of Obligated Group Members*"), the accounts of the members of the Obligated Group will be combined for financial reporting purposes and will be used in determining whether various covenants and tests contained in the Master Indenture (including tests relating to the incurrence of Additional Indebtedness) are met. The members of the Obligated Group currently consist of the Corporation, Wellmont Hawkins, Wellmont and Wellmont Foundation.

Parity Debt

The Corporation's obligation under the Loan Agreement to pay debt service on the Bonds will be secured by the Series 2011 Obligation. The Series 2011 Obligation is being issued on a parity with Master Indenture obligations issued to secure the following: (a) $12,966,415.15 outstanding principal amount of Series 2010 Bonds, (b) $55,000,000 outstanding principal amount of the Series 2007A Bonds, (c) $200,000,000 outstanding principal amount of the Series 2006C Bonds, (d) $59,580,000 outstanding principal amount of the Series 2005 Bonds, (e) $33,035,000 outstanding principal amount of the Series 2003 Bonds, and (f) any Additional Indebtedness issued, from time to time, under and pursuant to the Master Indenture.

The Loan Agreement provides that the Corporation is required to make designated payments to the Trustee for deposit into the Bond Fund in amounts sufficient to pay the principal of and interest on the Bonds when due.

Limited Obligations

The Bonds and the interest and premium, if any, payable thereon do not constitute a debt or liability of Sullivan County, the State of Tennessee or any political subdivision thereof other than the Issuer, but are payable solely from the funds pledged therefor in accordance with the Indenture. The issuance of the Bonds does not directly, indirectly or contingently, obligate the County, the State or any political subdivision thereof to levy any form of taxation for the payment thereof or to make any appropriation for their payment. The Bonds and the interest and premium, if any, payable thereon do not now and will never constitute a debt of the State within the meaning of the Constitution or the statutes of the State and do not now and will never constitute a charge against the credit or taxing power of the County, the State or any political subdivision thereof. Neither the County nor the State will in

any event be liable for the payment of the principal of, premium, if any, or interest on the Bonds or for the performance of any pledge, mortgage, obligation or agreement of any kind whatsoever which may be undertaken by the Issuer. No breach by the Issuer of any such pledge, mortgage, obligation or agreement may impose any pecuniary liability upon the County or the State or any charge upon its general credit or against its taxing power. The Issuer has no taxing power.

The Master Indenture

The Series 2011 Obligation will be issued as an Obligation under the Master Indenture. The members of the Obligated Group currently consist of the Corporation, Wellmont Hawkins, Wellmont and Wellmont Foundation. The members of the Obligated Group are jointly and severally liable for the payment of the Series 2011 Obligation, all other Obligations issued under the Master Indenture and for performance of the covenants and agreements set forth in the Master Indenture and the Eleventh Supplemental Master Indenture. Subject to certain conditions, the Master Indenture will permit additional entities to become members of the Obligated Group thereunder and will permit members of the Obligated Group to designate any or all of their respective affiliates as Restricted Affiliates for the purposes of the Master Indenture. Members of the Obligated Group will also be obligated to cause their respective Restricted Affiliates (such Restricted Affiliates, together with the Obligated Group, being herein referred to collectively as the "Combined Group") to make such payments and perform such covenants and agreements as are necessary for the Combined Group to comply with the Master Indenture. The Master Indenture also permits members of the Obligated Group and Restricted Affiliates to withdraw from the Combined Group under specified conditions, whereupon such withdrawing members of the Obligated Group and Restricted Affiliates will cease to be bound by the Master Indenture and no longer obligated to pay the sums due under all Obligations, including the Series 2011 Obligation.

See APPENDIX C – "SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE" for further information regarding the Master Indenture, including a discussion of the conditions under which entities will be permitted to join or withdraw from the Combined Group, the provisions regarding the incurrence of and security for additional Obligations or other Indebtedness and the various financial and operating covenants and agreements to be performed by the Combined Group.

At the time of issuance of the Series 2011 Obligation, the only other Obligations Outstanding under the Master Indenture will be the Series 2003 Obligation, the Series 2005 Obligation, the Series 2006C Obligation, the Series 2007A Obligation and the Series 2010 Obligation.

Additional Indebtedness Under the Master Indenture

The Master Indenture permits the 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 an Obligation. See APPENDIX C – "SUMMARY OF THE FINANCING DOCUMENTS – SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE." Additional Indebtedness may be issued to the Issuer or to persons other than the Issuer. Except to the extent entitled to the benefits of additional security as permitted by the Master Indenture and except for Subordinated Indebtedness, all Obligations issued under the Master Indenture will be equally and ratably secured thereby.

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 healthcare 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 Financing Documents. The Master Indenture provides that Supplemental Master Indentures pursuant to which one or more series of 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 Obligations secured thereby.

Limitations on Remedies

The rights of the Trustee, the Master Trustee, the holders of Master Indenture Obligations, and the holders of the Bonds may be limited by (i) bankruptcy, insolvency, or other similar laws affecting the enforcement of creditors' rights and (ii) general principles of equity, including the exercise of judicial discretion in appropriate cases. See also "RISK FACTORS".

THE FINANCING PLAN

General

The Bonds are being issued for the purpose of refunding bonds previously issued to provide financing for the Corporation. Proceeds of the Bonds will also be used to pay costs incurred in connection with the issuance of the Bonds. See "Sources and Uses of Funds".

The Refunding Plan

To provide financing for the benefit of the Corporation, the Issuer previously issued its Hospital Revenue Refunding Bonds (Wellmont Health System Project), Tax-Exempt Series 2006A (the "Series 2006A Bonds"), which are now outstanding in the aggregate principal amount of $76,595,000. The Series 2006A Bonds are not subject to optional redemption until March 1, 2013. In order to refund the Series 2006A Bonds, the Corporation made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds have agreed to tender their Series 2006A Bonds to the Corporation. Proceeds of the Bonds will be used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds will be purchased by the Corporation on the date of issuance of the Bonds and will be immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

Sources and Uses of Funds

The estimated sources and uses of funds for the financing plan are as follows (rounded to the nearest whole dollar):

Table 1. Sources and Uses of Funds

Sources of Funds	
Principal amount of Bonds	$76,165,000
Total sources	$76,165,000
Uses of Funds	
Purchase and retirement of Series 2006A Bonds	$74,942,165
Costs of issuance of the Bonds [(1)]	1,222,835
Total uses	$76,165,000

Note (1) Includes underwriter's discount, legal and accounting fees, printing costs, rating agency fees, and other costs of issuance. Costs of issuance in excess of available Bond proceeds will be paid by the Corporation with its own funds.

Debt Service Requirements on the Bonds

The following table contains the estimated debt service requirements on the Bonds.

Table 2. Debt Service Requirements on Bonds

Bond Year Ending September 1	Debt Service on Bonds		Total Debt Service
	Principal	Interest	
2011	$ 0	$ 1,526,947	$ 1,526,947
2012	0	4,738,800	4,738,800
2013	865,000	4,738,800	5,603,800
2014	890,000	4,686,900	5,576,900
2015	990,000	4,633,500	5,623,500
2016	1,390,000	4,574,100	5,964,100
2017	1,155,000	4,490,700	5,645,700
2018	1,205,000	4,421,400	5,626,400
2019	1,285,000	4,349,100	5,634,100
2020	5,585,000	4,272,000	9,857,000
2021	5,595,000	3,936,900	9,531,900
2022	5,895,000	3,601,200	9,496,200
2023	4,090,000	3,247,500	7,337,500
2024	4,280,000	3,002,100	7,282,100
2025	4,480,000	2,745,300	7,225,300
2026	4,680,000	2,476,500	7,156,500
2027	4,980,000	2,195,700	7,175,700
2028	5,175,000	1,872,000	7,047,000
2029	5,475,000	1,535,625	7,010,625
2030	5,775,000	1,179,750	6,954,750
2031	6,075,000	804,375	6,879,375
2032	6,300,000	409,500	6,709,500
Total	**$76,165,000**	**$69,438,697**	**$145,603,697**

THE ISSUER

The Issuer was incorporated as a public nonprofit corporation on August 31, 1979, by Sullivan County, Tennessee (the "County"), pursuant to the Act. The Issuer was organized to assist hospital institutions in providing facilities and structures for the development and maintenance of the public health, thereby providing County residents with access to adequate medical care and hospital facilities to improve their welfare, prosperity, health and living conditions. The Issuer is authorized by the Act to issue revenue bonds payable solely from the revenues and receipts from such facilities and structures or other sources designated by the Issuer and secured by a pledge of such revenues and receipts. The Issuer may issue bonds to refund any prior issues of its bonds.

Neither the County nor the State will in any event be liable for the payment of principal of, premium, if any, or interest on the Bonds or other bonds issued by the Issuer or for the performance of any pledge, mortgage, obligation or agreement of any kind undertaken by the Issuer. None of the bonds issued by the Issuer, including the Bonds, and none of the Issuer's agreements and obligations are an indebtedness of the County, the State or any political subdivision thereof within the meaning of any constitutional or statutory provision or otherwise. The Issuer has no taxing power.

The Issuer has full power and authority under the Act to enter into the Indenture and the Loan Agreement and to perform its covenants and obligations thereunder.

The Issuer is governed by a seven member Board of Directors appointed by the Board of Commissioners of the County. Members of the Board of Directors serve staggered 6-year terms.

Although the Issuer has consented to the use of this Official Statement in connection with the offer and sale of the Bonds, it has not participated in the preparation of this Official Statement and makes no representation as to its accuracy or completeness.

THE CORPORATION AND THE OBLIGATED GROUP

The Corporation is a nonprofit corporation under the laws of the State of Tennessee and is a 501(c)(3) organization under the Internal Revenue Code. Wellmont Foundation and Wellmont Hawkins are also nonprofit corporations organized under the laws of the State of Tennessee and are also 501(c)(3) organizations under the Internal Revenue Code. Wellmont is a Tennessee corporation. The Corporation, Wellmont, Wellmont Foundation and Wellmont Hawkins are currently the only members of the Obligated Group. For information about the Corporation and the Obligated Group, see APPENDIX A.

RISK FACTORS

General

The Bonds are special limited obligations of the Issuer payable solely from the revenues pledged to the payment of the Bonds in accordance with the Indenture, as described herein. The Bonds do not constitute a debt of the Issuer within any constitutional or statutory provision and do not give rise to a pecuniary liability of the Issuer. No Holder of any of the Bonds shall ever have the right to enforce payment of the Bonds against any property of the Issuer or any funds other than those expressly pledged under the Indenture to the payment thereof. The Bonds are payable solely from and secured by the Trust Estate, as described under "SOURCE OF PAYMENT AND SECURITY."

There are certain factors herein that may adversely affect the Corporation's ability to make timely payments under the Loan Agreement and the Obligated Group's obligation to make timely payments on the Series 2011 Obligation. Such failure could, among other things, result in an acceleration of the Bonds. No representation or assurance can be made that revenues will be realized by the Corporation or the Obligated Group in amounts sufficient to pay maturing principal of, premium, if any, and interest due on the Bonds or payment of the Series 2011 Obligation. Purchasers of the Bonds should bear in mind that the occurrence of any number of events, some of which are specified in more detail below, could adversely affect the revenue-producing ability of the Corporation and the Obligated Group. Further, economic and other conditions, including demand for hospital services, the ability of the Corporation and the Obligated Group to provide the services required by patients, physicians' confidence in the Corporation and the Obligated Group, economic conditions in the service area of the Corporation and the Obligated Group, competition, rates, costs, third-party reimbursement and governmental regulations, may adversely affect the Corporation's and the Obligated Group's revenues and, in turn, the payment of principal of, premium, if any, and interest on the Bonds and payment of the Series 2011 Obligation.

THERE CAN BE NO ASSURANCE THAT THE REVENUES OF THE CORPORATION AND THE OBLIGATED GROUP OR UTILIZATION OF THE OBLIGATED GROUP'S HEALTHCARE FACILITIES WILL NOT DECREASE.

The following risk factors, among others, should be considered in evaluating the ability of the Obligated Group, including the Corporation, to provide sufficient revenues for payment of the principal of, premium, if any, and interest on the Bonds and payment of the Series 2011 Obligation. This discussion of risk factors is not, and is not intended to be, exhaustive.

Market Risk

There can be no assurance that there will be a secondary market for the Bonds. In the absence of such a market for the Bonds could result in investors not being able to resell the Bonds should they need to.

Impact of Market Turmoil

The disruption of the credit and financial markets in the last several years has led to volatility in the securities markets, significant losses in investment portfolios, increased business failures and consumer and business bankruptcies, and is a major cause of the current economic crisis. In response to that disruption, the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") was enacted and approved by the President on July 21, 2010. The Financial Reform Act includes broad changes to the existing financial regulatory structure, including the creation of new federal agencies to identify and respond to risks to the financial stability of the United States. Additional legislation is pending or under active consideration by Congress and regulatory action is being considered by various Federal agencies and the Federal Reserve Board and foreign governments, which are intended to increase the regulation of domestic and global credit markets. The effects of the Financial Reform Act and of these legislative, regulatory and other governmental actions, if implemented, are unclear.

The health care sector, including the Corporation and the Obligated Group, has been materially and adversely affected by this market turmoil. The consequences of this market turmoil have generally included, among other things, realized and unrealized investment portfolio losses, increased borrowing costs and periodic disruption of access to the capital markets.

The Corporation and the Obligated Group have experienced some impact from current economic conditions, but the payor mix of the Corporation and the Obligated Group is stable. Bad debt of the Corporation and the Obligated Group has increased as employers and insurers shift additional financial responsibility to the patient. Patients have delayed some elective business but outpatient surgical volume is up 6.6 percent for the six-month period ended December 31, 2010 over the six-month period ended December 31, 2009. While the budgets for the States of Tennessee and Virginia are under stress, reductions in amounts provided by the State of Tennessee to the Corporation and the Obligated have been offset by the assessment fee. The Corporation and the Obligated Group expect to receive a cut of approximately $450,000 for the upcoming year from the State of Virginia. See "RISK FACTORS - Patient Service Revenues" and in APPENDIX A – "Historical Financial Information", and "Management's Discussion and Analysis of Financial Information".

In February 2009, the American Recovery and Reinvestment Act of 2009 ("H.R. 1") was enacted and includes several provisions that are intended to provide financial relief to the health care sector, most of which will be spent by 2011. These funds include, among other things, a temporary increase in Federal payments to states to fund the Medicaid program, a requirement that states promptly reimburse healthcare providers, and a subsidy to the recently unemployed for health insurance premium costs. H.R. 1 also establishes a framework for the implementation of a nationally-based health information technology program. For more information on this program, see "The HITECH Act" below.

Health Care Reform

In March, 2010, the Patient Protection and Affordable Care Act (the "Health Care Reform Act") was enacted and approved by the President. Some of the provisions of the Health Care Reform Act took effect immediately, while others will take effect or will be phased in over time, ranging from a few months following approval to ten years. Because of the complexity of the Health Care Reform Act generally, additional legislation is likely to be considered and enacted over time. The Health Care Reform Act will also require the promulgation of substantial regulations with significant effects on the health care industry and third-party payors. In response, third-party payors and suppliers and vendors of goods and services to health care providers are expected to impose new and additional contractual terms and conditions. Thus, the health care industry will be subjected to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges, for a substantial period of time.

A significant component of the Health Care Reform Act is reformation of the sources and methods by which consumers will pay for health care for themselves and their families and by which employers will procure health insurance for their employees and dependents and, as a consequence, expansion of the base of consumers of health care services. One of the primary drivers of the Health Care Reform Act is to provide or make available, or subsidize the premium costs of, health care insurance for some of the millions of currently uninsured (or underinsured) consumers who fall below certain income levels. The Health Care Reform Act proposes to

accomplish that objective through various provisions, summarized as follows: (i) the creation of active markets (referred to as exchanges) in which individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents, (ii) providing subsidies for premium costs to individuals and families based upon their income relative to federal poverty levels, (iii) mandating that individual consumers obtain and certain employers provide a minimum level of health care insurance, and providing for penalties or taxes on consumers and employers that do not comply with these mandates, (iv) expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps, and (v) expansion of existing public programs, including Medicaid, for individuals and families. The Congressional Budget Office ("CBO") has estimated that in federal fiscal year 2015, 19 million consumers who are currently uninsured will become insured, followed by an additional 11 million consumers in federal fiscal year 2016. To the extent all or any of those provisions produce the expected result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected and bad debt expenses may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues.

Some of the specific provisions of the Health Care Reform Act that may affect hospital operations, financial performance or financial conditions, including those of the Members of the Obligated Group, are described below. This listing is not, is not intended to be, nor should be considered by the reader as, comprehensive. The Health Care Reform Act is complex and comprehensive, and includes a myriad of new programs and initiatives and changes to existing programs, policies, practices and laws. At this time, management of the Corporation cannot predict the aggregate effect of the Health Care Reform Act upon the Obligated Group, as a whole.

- Commencing upon enactment through September 30, 2019, the annual Medicare market basket updates for hospitals will be reduced. Beginning October 1, 2011, the market basket updates will be subject to productivity adjustments. The reductions in market based updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are relatively more dependent upon Medicare than other providers. Additionally, the reductions in market basket updates will be effective prior to the periods during which insurance coverage and the insured consumer base will expand, which may have an interim negative effect on revenues. The combination of reductions to the market basket updates and the imposition of the productivity adjustments may, in some cases and in some years, result in reductions in Medicare payment per discharge on a year-to-year basis.

- Commencing October 1, 2010 through September 30, 2019, payments under the "Medicare Advantage" programs (Medicare managed care) will be reduced, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans. Those beneficiaries may terminate their participation in those plans and opt for the traditional Medicare fee-for-service program. The reduction in payments to Medicare Advantage programs may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs. All or any of these outcomes will have a disproportionately negative effect upon those providers with relatively high dependence upon Medicare managed care revenues.

- Commencing October 1, 2012, a value-based purchasing program will be established under the Medicare program designed to provide incentive payments to hospitals based on performance on quality and efficiency measures. These incentive payments are funded through a pool of money collected from all hospital providers.

- Commencing October 1, 2013, Medicare disproportionate share hospital ("DSH") payments will be reduced initially by 75%. DSH payments will be increased thereafter to account for the national rate of consumers who do not have health care insurance and are provided uncompensated care. Commencing October 1, 2013, each state's Medicaid DSH allotment from federal funds will be reduced.

- Expansion of Medicaid programs to a broader population with incomes up to 133% of federal poverty levels. CBO has estimated that 16 million consumers who are currently uninsured will

become newly eligible for Medicaid through 2019 as a result of this expansion. Providers operating in markets with large Medicaid and uninsured populations are anticipated to benefit from increased revenues resulting from increased utilization and reductions in bad debt or uncompensated care. The increase in utilization can also be expected to increase in costs of providing that care, which may or may not be balanced by increased revenues.

- Commencing October 1, 2012, Medicare payments that would otherwise be made to hospitals that have a high rate of potentially preventable readmissions of Medicare patients for certain clinical conditions will be reduced by specified percentages to account for those excess and "preventable" hospital readmissions.

- Commencing October 1, 2014, Medicare payments to certain hospitals for hospital-acquired conditions will be reduced by 1%. Commencing July 1, 2011, federal payments to states for Medicaid services related to health care-acquired conditions will be prohibited.

- Commencing October 1, 2011, health care insurers will be required to include quality improvement covenants in their contracts with hospital providers, and will be required to report their progress on such actions to the Secretary of Health and Human Services ("HHS"). Commencing January 1, 2015, health care insurers participating in the health insurance exchanges will be allowed to contract only with hospitals that have implemented programs designed to ensure patient safety and enhance quality of care. The effect of these provisions upon the process of negotiating contracts with insurers or the costs of implementing such programs cannot be predicted.

- With varying effective dates, the Health Care Reform Act enhances the ability to detect and reduce waste, fraud, and abuse in public programs through provider enrollment screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. The Health Care Reform Act requires the development of a database to capture and share health care provider data across federal health care programs and provides for increased penalties for fraud and abuse violations, and increased funding for anti-fraud activities.

- Effective for tax years commencing immediately after approval, additional requirements for tax-exemption will be imposed upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the amount generally charged to insured patients; and control the billing and collection processes. Additionally, effective for tax years commencing January 1, 2013, tax-exempt hospitals must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax-exempt status.

- The establishment of an Independent Payment Advisory Board to develop proposals to improve the quality of care and limitations on cost increases. Beginning January 15, 2019, if the Medicare growth rate exceeds the target the Board is required to develop proposals to reduce the growth rate and require the Secretary of HHS to implement those proposals, unless Congress enacts legislation related to the proposals.

The Health Care Reform Act creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models and to implement various demonstration programs and pilot projects to test, evaluate, encourage and expand new payment structures and methodologies to reduce health care expenditures while maintaining or improving quality of care, including bundled payments under Medicare and Medicaid, and comparative effectiveness research programs that compare the clinical effectiveness of medical treatments and develop recommendations concerning practice guidelines and coverage determinations. Other provisions encourage the creation of new health care delivery programs, such as accountable care organizations or combinations of provider organizations, which voluntarily meet quality thresholds to share in the cost savings they achieve for the

Medicare program. The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted.

Lawsuits have been filed and additional ones may be filed challenging the constitutionality of the Health Care Reform Act. Two federal district court judges of the United States District Court for the Eastern District of Virginia and the Northern District of Florida, respectively, have ruled that the "individual mandate," requiring most individuals to maintain a minimum level of health insurance by 2014 or be subject to a penalty, is unconstitutional, with the District Court judge for the Northern District of Florida concluding that the entire Health Care Reform Act must be declared void. On March 3, 2011, the District Court judge for the Northern District of Florida stayed his ruling pending an appeal to the 11th Circuit U.S. Court of Appeals; an appeal was subsequently filed on March 8, 2011. Similar challenges filed in other District Courts have been dismissed but are on appeal and arguments in a number of other cases remain pending. In addition, on January 19, 2011, the United States House of Representatives approved a bill to overturn the Health Care Reform Act. However, on February 6, 2011, the U. S. Senate rejected a bill to repeal the Health Care Reform Act. The ultimate outcome of these lawsuits, and any additional legislative challenges, and their effect on the Health Care Reform Act is unknown.

Management of the Corporation is analyzing the Health Care Reform Act and will continue to do so in order to assess the effects of the legislation and evolving regulations on current and projected operations, financial performance and financial condition. However, management cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the legislation.

Nonprofit Healthcare Environment

The Obligated Group Members other than Wellmont, Inc. are nonprofit corporations, exempt from federal income taxation as organizations described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). As nonprofit tax-exempt organizations, the Obligated Group Members other than Wellmont, Inc. are subject to federal, state and local laws, regulations, rulings and court decisions relating to their organization and operation, including their operation for religious and charitable purposes. At the same time, the Obligated Group Members conduct large-scale complex business transactions and are often the major employers in their geographic areas. There can often be a tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of a complex, multi-state healthcare organization.

Over the past several years, an increasing number of the operations or practices of healthcare providers have been challenged or questioned to determine if they are consistent with the regulatory requirements for nonprofit tax-exempt organizations. These challenges are broader than concerns about compliance with federal and state statutes and regulations, such as Medicare and Medicaid compliance, and instead in many cases are examinations of core business practices of the healthcare organizations. Areas which have come under examination have included pricing practices, billing and collection practices, charitable care, executive compensation, exemption of property from real property taxation, and others. These challenges and questions have come from a variety of sources, including state attorneys general, the Internal Revenue Service (the "IRS"), labor unions, Congress, state legislatures, and patients, and in a variety of forums, including hearings, audits and litigation. These challenges or examinations include the following, among others:

Congressional Hearings. In recent years, three congressional committees have conducted hearings and other proceedings inquiring into various practices of nonprofit hospitals and healthcare providers. The Health Care Reform Act, discussed above, contains many features from previous tax exemption reform proposals. It does not mandate specific levels of charity care for nonprofit hospitals, but it does include a set of sweeping changes applicable to charitable hospitals exempt under Section 501(c)(3) of the Code. The Health Care Reform Act (a) imposes new eligibility requirements for 501(c)(3) hospitals, coupled with an excise tax for failures to meet certain of those requirements; (b) requires mandatory IRS review of the hospital's entitlement to exemption; (c) sets forth new reporting requirements, including information related to community health needs assessments and audited financial statements; and (d) imposes further reporting requirements on the Secretary of the Treasury regarding charity care levels.

Internal Revenue Service Examination of Compensation Practices. In August 2004, the IRS announced a new enforcement effort to identify and halt abuses by tax-exempt organizations that pay excessive compensation and

benefits to their officers and other insiders. The IRS announced that it would contact nearly 2,000 charities and foundations to seek more information about their compensation practices and procedures. In February 2009, the IRS issued its Hospital Compliance Project Final Report (the "IRS Final Report") based on its examination of such tax-exempt organizations. The IRS Final Report indicates that the IRS (i) will continue to heavily scrutinize executive compensation arrangements, practices and procedures and (ii) in certain circumstances, may conduct further investigations or impose fines on tax-exempt organizations.

Litigation Relating to Billing and Collection Practices. Lawsuits have been filed alleging, among other things, that hospitals have failed to fulfill their obligations to provide charity care to uninsured patients and have overcharged uninsured patients. Many of these cases have since been dismissed by the courts but a number of cases are still pending in various courts around the country with inconsistent results. While it is not possible to make general predictions, some hospitals and health systems have entered into substantial settlements. Currently, no Obligated Group Members have been named as defendants in any action alleging failure to fulfill obligations to provide charity care to uninsured patients or overcharging uninsured patients.

Challenges to Real Property Tax Exemptions. Recently, the real property tax exemptions afforded to certain nonprofit healthcare providers by state and local taxing authorities have been challenged on the grounds that the healthcare providers were not engaged in charitable activities. These challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices and excessive financial margins. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements. While the Corporation is not aware of any current challenge to the tax exemption afforded to any material real property of the Obligated Group Members, there can be no assurance that these types of challenges will not occur in the future.

The foregoing are some examples of the challenges and examinations facing nonprofit healthcare organizations. They are indicative of a greater scrutiny of the billing, collection and other business practices of these organizations, and may indicate an increasingly more difficult operating environment for healthcare organizations, including the Obligated Group. The challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on the Obligated Group.

Charity Care

Hospitals are permitted to obtain tax-exempt status under the Code because the provision of health care historically has been treated as a "charitable" enterprise. This treatment arose before most Americans had health insurance, when charitable donations were required to fund the health care provided to the sick and disabled. Some commentators and others have taken the position that, with the onset of employer health insurance and governmental reimbursement programs, there is no longer any justification for special tax treatment for the health care industry, and the availability of tax-exempt status should be eliminated. Federal and state tax authorities are also beginning to demand that tax-exempt hospitals justify their tax-exempt status by documenting their charitable care and other community benefits.

As described above under the caption, "Health Care Reform," the Health Care Reform Act imposes additional requirements for tax-exemption upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the amounts generally billed to insured patients; and control the billing and collection processes. Additionally, effective for tax years commencing after March 23, 2012, tax-exempt hospitals must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs.

Failure to complete a community health needs assessment in any applicable three-year period can result in a penalty on the organization of up to $50,000, in addition to possible revocation of status as a section 501(c)(3) organization.

The Health Care Reform Act also imposes new reporting and disclosure requirements on hospital organizations. The IRS is required to review information about a hospital's community benefit activities at least once every three years. The Health Care Reform Act requires the Secretary of the Treasury, in consultation with the Secretary of HHS, to submit annually a report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government programs, as well as costs incurred by tax-exempt hospitals for

community benefit activities. The Secretary of the Treasury, in consultation with the Secretary of HHS, must conduct a study of the trends in these amounts, and subject a report on such study to Congress not later than five years after the date of enactment of the Health Care Reform Act. These statutorily mandated requirements for periodic review and submission of reports relating to community benefit provided by section 501(c)(3) hospital organizations may increase the likelihood that Congress will consider additional requirements for section 501(c)(3) hospital organizations in the future and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

Parity Debt and Additional Indebtedness

The Bonds are secured under the Master Indenture on a parity with (a) approximately $360,581,415 aggregate outstanding principal amount of other long-term Indebtedness and (b) any Additional Indebtedness (as defined in APPENDIX C) issued, from time to time, under and pursuant to the Master Indenture. Additional debt, whether or not secured by the Master Indenture, will increase debt service requirements and could adversely affect debt service coverage on the Bonds and the availability of the Obligated Group to meet its obligations under the Series 2011 Obligation.

Limitations on Enforcement

The enforcement of the Indenture, the security interest in the funds held by the Trustee granted therein, and the rights of the Trustee in funds held under the Indenture may be limited by a number of factors, including: (a) provisions prohibiting the direct payment of amounts due to healthcare providers from Medicaid and Medicare programs to persons other than such providers; (b) certain judicial decisions which cast doubt upon the right of the Trustee, in the event of the bankruptcy of the Corporation or the Obligated Group, to collect and retain accounts receivable from Medicare, TennCare, Medicaid, and other governmental programs; (c) state and federal laws giving super priority to certain kinds of statutory liens, such as tax liens; (d) rights arising in favor of the United States of America or any agency thereof; (e) constructive trusts, equitable or other rights impressed or conferred by a federal or state court in the exercise of its equitable jurisdiction; (f) Bankruptcy Laws which may affect the right of the Trustee to collect and retain accounts receivable from Medicare, TennCare, Medicaid and other governmental programs; (g) state laws affecting the continuation of perfected and first priority security interests granted by the Corporation, the Obligated Group or the Issuer, including the Deed of Trust; and (h) claims that might arise if appropriate financing or continuation statements are not filed in accordance with the Uniform Commercial Code as from time to time in effect in Tennessee and Virginia.

The ability of the Trustee to enforce the terms and agreements set forth in the Loan Agreement and in the Series 2011 Obligation may be limited by laws relating to bankruptcy, insolvency, reorganization or moratorium and by other similar laws affecting creditors' rights. In addition, the Trustee's ability to enforce such terms will depend upon the exercise of various remedies specified by such document which may in many instances require judicial actions that are often subject to discretion and delay or that otherwise may not be readily available or be limited.

The remedies available to the Trustee or to the Owners of the Bonds upon an event of default under the Indenture 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 the Bankruptcy Law, the remedies provided in the Indenture and under the Bonds may not be readily available or may be limited.

The Corporation and the Obligated Group

General. The ability of the Corporation to make the payments under the Loan Agreement, the Obligated Group to make payments on the Series 2011 Obligation sufficient to provide debt service on the Bonds and the Obligated Group to make other payments provided for under the Master Indenture depends solely upon the receipt by the Corporation and the Obligated Group of sufficient revenues from their operations in excess of their expenses of operation. A number of risks which could prevent the Corporation and the Obligated Group from receiving such amounts are outlined below. No representation or assurance can be given that revenues will be realized by the Corporation in amounts sufficient to pay principal of, premium, if any, and interest on the Bonds or the Obligated Group in amounts sufficient to pay the Series 2011 Obligation and the other amounts owed under the Master Indenture. Future economic and other conditions, including demand for healthcare services, the ability of the Corporation and the Obligated Group to provide the services required by patients, physicians' confidence in the

Corporation and the Obligated Group, return on investments made by the Corporation, including investments in other enterprises, economic developments in the service area and competition from other healthcare institutions in the service area, together with changes in rates, costs, third party reimbursement and governmental regulation, may adversely affect revenues and expenses and, consequently, the Corporation's and the Obligated Group's ability to make such payments. The future financial condition of the Corporation and the Obligated Group could also be adversely affected by, among other things, legislation, regulatory actions, increased competition from other healthcare providers, demand for healthcare services, demographic changes, changes in the local economy, the increasing cost of malpractice insurance, malpractice claims and other litigation and a number of other conditions which are unpredictable.

While an identification of all additional risk factors possibly affecting operations of the Corporation and the Obligated Group in the future cannot be accomplished, a discussion of certain risk factors follows. This discussion of risk factors is not, and is not intended to be, exhaustive. Some of the changes that are possible in the future include the following:

(a) Legislation or regulations, including federal healthcare reform legislation, which could increase the operating costs of the Corporation and the Obligated Group or further limits the payment of operating costs and the payment or reimbursement of capital costs, would adversely affect the operating costs of the Corporation and the Obligated Group.

(b) Reductions in the funding levels and reimbursement levels of the Medicare, TennCare or Medicaid programs and other legislative and regulatory changes which further reduce Medicare, TennCare or Medicaid reimbursement to hospitals. See "Patent Service Revenues - Medicare and Medicaid Programs" herein.

(c) Future contract negotiations between the Corporation and the Obligated Group, and public and private insurers, health maintenance organizations and preferred provider organizations and efforts of other entities and employers to limit hospitalization costs which could adversely affect the utilization and the level of reimbursement to the Corporation and the Obligated Group.

(d) Increased unemployment or other adverse economic conditions increased cost and decreased availability of health insurance which could increase the proportion of patients who are uninsured or who are otherwise unable to pay fully for the cost of their care, and increased numbers of patients suffering from uninsured illnesses.

(e) There have been and may be in the future a number of state and federal legislative proposals and enactments which have as one of their principal purposes the stimulation of competition in the healthcare industry. Competition from healthcare providers located in the service area of the Corporation and the Obligated Group, from other types of healthcare providers that may offer comparable healthcare services and from alternative or substitute healthcare delivery systems or programs, may decrease utilization of the Corporation's and the Obligated Group's healthcare facilities. In addition, the development of future medical and other scientific advances may result in decreased usage of inpatient hospital facilities. Efforts by insurers, employer-purchasers of healthcare insurance and governmental agencies to reduce utilization of hospital facilities by such means as preventive medicine, improved occupational health and safety standards, the possibility of future unionization and more extensive utilization of outpatient care at facilities not related to the healthcare facilities of the Corporation and the Obligated Group could adversely affect the operations of the Corporation and the Obligated Group. Also, the growth and development of health maintenance organizations, preferred provider organizations and other managed care programs may result in decreased usage of inpatient Corporation and Obligated Group facilities.

(f) In recent years, numerous hospitals have closed their doors, annual admissions to hospitals have dropped and annual patient days have been reduced. In addition to competition from other facilities, a number of other factors have been reducing hospitalization nationwide and in Tennessee. Physicians' practice patterns indicate a trend to fewer inpatient admissions and shorter length of stay for those who are admitted. Third-party payors such as Medicare, Medicaid and Blue Cross have exerted

efforts to contain their costs by reviewing and questioning the need for certain inpatient admissions and the length of hospital stays. Insurers and managed care organizations are attempting to use various cost control methods to attempt to provide employers with adequate but low cost insurance programs for their employees. To minimize the cost of such health insurance programs, insurers and managed care organizations are offering products which include such elements as higher deductibles, pre-admission review, concurrent hospital review, retrospective review and other provisions, which tend to reduce hospital admissions and stays and, accordingly, healthcare revenues. It is impossible to predict at this time the extent to which such trends and actions will affect the Corporation and the Obligated Group and its operations.

(g) Operation of certain healthcare facilities of the Corporation and the Obligated Group necessitates the production of waste products, including certain radioactive wastes, infectious wastes and hazardous wastes as defined in federal and state laws. As the generator of these wastes, the Corporation and the Obligated Group are responsible for compliance with applicable federal, state and local laws and regulations, including the proper handling, labeling, storage, transport and disposal of the wastes, and may incur liability without regard to fault or remedial actions and for personal injury and property damage related to a release or threatened release of these wastes. Such liability could be substantial and may adversely affect the Corporation's and the Obligated Group's financial condition.

(h) Availability of nurses and other qualified healthcare technicians and personnel is an important factor to the Corporation and the Obligated Group. Healthcare facilities nationwide are experiencing a shortage in the number of nurses available and qualified to perform nursing services. The nursing shortage has forced many hospitals to increase nursing salaries and has caused some to cut back operations. Efforts to organize nurses and other nursing and technical personnel into collective bargaining units have resulted at times in adverse labor actions and conditions. The occurrence of any of these events could adversely impact future operations of the Corporation and the Obligated Group.

(i) Unforeseen labor actions could result in a substantial decrease in revenues of the Corporation and the Obligated Group without corresponding decreases in costs.

(j) The occurrence of natural disasters, including hurricanes, floods and earthquakes, may damage the Corporation and the Obligated Group, interrupt utility service thereto, or otherwise impair Corporation and Obligated Group operations and the generation of revenues therefrom. Although the Corporation and the Obligated Group are covered by general property insurance in an amount which management considers to be sufficient to provide for the replacement of such facilities in the event of such a natural disaster, there is no assurance that such insurance would in fact be adequate to do so.

(k) Availability of revenues in the event of bankruptcy of the Corporation, the Obligated Group or related entities. Certain judicial decisions have cast doubt upon the right of a bond trustee, in the event of a hospital's bankruptcy, to collect and retain for the benefit of Bondholders portions of revenues consisting of Medicare, TennCare, Medicaid and other governmental receivables.

(l) Potential depletion of the Medicare Trust Fund, as projected by various studies.

(m) The cost and availability of medical malpractice insurance for medical personnel working or practicing in the hospitals.

(n) Other risk factors may also affect the operation of the Corporation and the Obligated Group, including without limitation the following: (1) the cost and availability of energy; (2) the cost and availability of insurance, such as fire, general comprehensive liability and excess liability, that healthcare facilities of a similar size and type generally carry; (3) uninsured acts of God; (4) imposition of wage and price controls for the healthcare industry; (5) decrease in population in the Corporation's and the Obligated Group's service areas; (6) reduced need for services arising from future medical and scientific advances; (7) preventive medicine; (8) improved occupational health and safety and improved outpatient care which could result in decreased usage of Corporation and Obligated Group facilities; (9) the impact of a pandemic or other need for surge capacity at Corporation and Obligated Group facilities and (10) an increase in the

rate of inflation and difficulties in increasing service charges and other fees, while at the same time maintaining the quantity and quality of healthcare services, may affect the ability of the Corporation and the Obligated Group to maintain sufficient operating margins.

Financial Information. Certain financial and operating information in connection with the Obligated Group (which includes the Corporation) is set forth in APPENDICES A and B. There can be no assurance that the financial results achieved by the Obligated Group in the future will be similar to historical results set forth in APPENDICES A and B. Such future results will vary from historical results, and actual variations may be material. Therefore, the historical operating results of the Obligated Group cannot be taken as a representation that the Corporation will be able to generate sufficient revenues in the future to make payment of principal of, premium, if any, and interest on the Bonds, that the Corporation will be able to generate sufficient revenues in the future to make payments on the Series 2011 Obligation and that the Obligated Group will be able to generate sufficient revenues in the future to make payment on the other indebtedness owed under the Master Indenture.

Risks Related to Corporation and Obligated Group Operations. Through various changes in governmental policy, advances in technology and treatment, increased costs of operations, increased charges, changes in payment methodology, utilization review and greater competition, inpatient hospitalizations have generally decreased in recent years. It is uncertain whether that decrease will continue, and to what extent the factors mentioned above will continue to create operational and economic uncertainty for hospitals. It is now generally acknowledged that hospital operations pose greater complexity and higher risk than in years past and this trend is expected to continue. It is not practical to enumerate each and every operating risk which may result from hospital operations, and certain risks or combinations of risks which are now unanticipated may have material adverse results in the future. Certain risks relating to hospital operations are enumerated below.

Equipment. Technological advances in recent years have accelerated the trend toward the use of sophisticated diagnostic and treatment equipment in hospitals. The availability of certain equipment may be a significant factor in hospital utilization, but in the near future purchase of such equipment may be subject to health planning agency approval on the federal or state level and the ability of the Corporation and the Obligated Group to finance such purchases. The cost of acquiring and maintaining such equipment may affect the ability of Corporation and Obligated Group to maintain sufficient operating margins. There is also the risk of material adverse impact from problems in implementing technology, in particular health care information systems.

Competition. The Corporation's and the Obligated Group's costs and revenues could be substantially affected by future changes in the number and mix of both patients and services brought about by increased competition among healthcare providers and insurers. This competition could take several different forms, including:

(a) Competition among hospitals to sell their services more cheaply to third-party payors;

(b) Competition from existing hospitals in the Corporation's and the Obligated Group's service area and from tertiary facilities in surrounding urban centers to offer new services or expand existing services or to reduce charges;

(c) Competition from nursing homes, home health agencies, ambulatory care facilities, surgical centers, rehabilitation and therapy centers, increasingly sophisticated physician group practices, and other non-hospital providers for many services for which patients currently rely on hospitals;

(d) Competition for patients from freestanding specialty hospitals which tend to provide only medical procedures with a high financial return, such as orthopedics, thus siphoning off potential revenue from full-service acute care hospitals;

(e) Competition for patients between physicians, who generally use hospitals, and non-physician practitioners such as nurse-midwives, nurse practitioners, chiropractors, physical and occupational therapists and others, who may not generally use hospitals;

(f) Competition for enrollees between traditional indemnity insurers, whose members generally have a free choice of hospitals and other providers, and health maintenance organizations or other prepaid plans, who either own their own hospitals or contract with hospitals and other providers and thus substantially restrict the providers from whom their members can receive healthcare services; and

(g) Competition from proprietary providers of healthcare, which proprietary providers may have access to equity capital markets to obtain funds with which to compete under financing instruments which generally do not restrict the operational flexibility of such providers to the degree that the tax-exempt capital market restricts the operations of the Corporation and the Obligated Group.

Medical Staff. A significant portion of the Corporation's and the Obligated Group's revenue is derived from charges to patients, or reimbursement from third-party intermediaries on behalf of patients, for treatment delivered to patients admitted to the Corporation's and the Obligated Group's healthcare facilities by members of its medical staff. There is no assurance that the medical staff will continue to do so, or, if they continue to do so, to do so in the same manner and numbers as before. Each physician on the medical staff has the option of admitting a particular patient, with the patient's consent, to one or another acute care hospital with which the physician is or may become affiliated.

Environmental Laws and Regulations. Healthcare providers are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations which address, among other things, provider operations or facilities and properties owned or operated by providers. The types of regulatory requirements faced by healthcare providers include, but are not limited to, air and water quality control requirements, waste management requirements, specific regulatory requirements applicable to asbestos, polychlorinated biphenyls, radioactive substances and other hazardous substances, requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the Corporation's and the Obligated Group's facilities and requirements for training employees in the proper handling and management of hazardous materials and wastes.

In their role as owners and/or operators of properties or facilities, healthcare providers may be subject to liability for investigating and remedying any hazardous substances which have come to be located on the property, including any such substances that may have migrated off the property. Typical healthcare provider operations include, but are not limited to, in various combinations, the handling, use, storage, transportation, incineration, disposal and/or discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants or contaminants. As such, healthcare provider operations are particularly susceptible to the practical, financial and legal risks associated with compliance with such laws and regulations. Such risks may result in damage to individuals, property or the environment, may interrupt operations and/or increase their cost, result in legal liability, damages, injunctions or fines, and result in investigations, administrative proceedings, penalties or other governmental agency actions.

At the present time, management of the Corporation and the Obligated Group is not aware of any pending or threatened claim, investigation or enforcement action regarding environmental issues which, if determined adversely to the Corporation and the Obligated Group, would have material adverse consequences to the operations or financial condition of the Corporation and the Obligated Group. There can be no assurance given, however, that the Corporation and the Obligated Group will not encounter environmental risks in the future, and such risks may result in material adverse consequences to the operations or financial condition of the Corporation and the Obligated Group.

Malpractice Insurance. The Corporation has malpractice and other insurance providing coverage in amounts that it has determined to be adequate to protect its property and operations. Malpractice and other claims, however, could adversely affect the financial position of the Corporation and the Obligated Group, as could substantial increases in the cost of malpractice insurance. There are currently no claims against the Hospital that exceed its insurance coverage limits.

Certain Bankruptcy Risks

In the event of bankruptcy of an Obligated Group Member, the rights and remedies of the Holders of the Bonds are subject to various provisions of the United States Bankruptcy Code. If an Obligated Group Member were to commence a proceeding in bankruptcy, payments made by that Obligated Group Member during the 90-day (or, in some circumstances, one-year) period immediately preceding the commencement may be avoided as preferential transfers to the extent payments allow the recipients thereof to receive more than they would have received in the event of the Obligated Group Member's liquidation and the other requirements set forth in Section 547(b) of the United States Bankruptcy Code have been met. Security interests and other liens granted to or perfected by a Trustee or the Master Trustee during the preference period may also be avoided as preferential transfers to the extent the security interest or other lien secures obligations that arose prior to the date of the grant or perfection. Such a bankruptcy filing would result in the imposition of an automatic stay of the commencement or continuation of any judicial or other proceeding against the Obligated Group Member and its property, and as an automatic stay of any act or proceeding to enforce a lien upon or to otherwise exercise control over its property as well as various other actions to enforce, maintain or enhance the rights of a Trustee and the Subordinate Master Trustee. If the bankruptcy court so ordered, the property of the Obligated Group Member could be used for the reorganization of the Obligated Group Member despite any security interest of the Trustee therein. The rights of the Trustee and the Master Trustee to enforce their respective interests and other liens could be delayed or altered during the pendency of the reorganization.

Such Obligated Group Member could file a plan for the adjustment of its debts in any bankruptcy proceeding which could include provisions modifying or altering the rights of creditors generally, or any class of them, secured or unsecured. The plan, when confirmed by a court, would bind all creditors who had notice or knowledge of the plan and, with certain exceptions, discharges all claims against the debtor to the extent provided for in the plan. No plan may be confirmed unless certain conditions are met, among which are conditions that the plan be feasible and that it shall either have been accepted by each class of claims impaired thereunder or, if the plan is not so accepted, the court shall have determined that the plan is fair and equitable with respect to each class of nonaccepting creditors impaired thereunder and does not discriminate unfairly. A class of claims has accepted the plan if at least two-thirds in dollar amount and more than one-half in number of the class cast votes in its favor.

In addition, the bankruptcy of a health plan or physician group that is a party to a significant managed care arrangement with one or more of the Obligated Group Members could have material adverse effects on the Obligated Group Members.

In the event of bankruptcy or insolvency of an Obligated Group Member, there is no assurance that certain covenants, including tax covenants, contained in the Indenture, the Loan Agreement or the Master Indenture and certain other documents would survive. Accordingly, a debtor or bankruptcy trustee could take action that would adversely affect the exclusion of interest on the Bonds from gross income of the Bondholders for federal income tax purposes.

Patient Service Revenues

Net patient revenues realized by the Obligated Group are derived from a variety of sources and will vary among the individual facilities owned and operated by the Obligated Group Members and also among the various market areas and regions in which the facilities are located. Certain facilities and regions may realize substantially more revenues from private payment programs, such as managed care organizations, than do others.

A substantial portion of the net patient service revenues of the Obligated Group is derived from third-party payors which pay for the services provided to patients covered by third parties for services. These third-party payors include the federal Medicare program, state Medicaid programs (including TennCare) and private health plans and insurers, including health maintenance organizations and preferred provider organizations. Many of those programs make payments to Members of the Obligated Group in amounts that may not reflect the direct and indirect costs of the Members of providing services to patients.

The financial performance of the Obligated Group has been and could be in the future adversely affected by the financial position or the insolvency or bankruptcy of or other delay in receipt of payments from third-party payors that provide coverage for services to their patients.

Medicare, Medicaid and TennCare Programs

Medicare and Medicaid are the commonly used names for reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Medicare is an exclusively federal program, and Medicaid is a combined federal and state program. Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older, blind, disabled or qualify for the End Stage Renal Disease Program. Medicare Part A covers inpatient hospital services, skilled nursing care and some home health care, and Medicare Part B covers physician services and some supplies. Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid. Medicaid is funded by federal and state appropriations and administered by the various states. As further discussed under the caption "Medicaid - Tennessee Medicaid Alternative" below, Tennessee implemented a program named TennCare as a Medicaid alternative in 1994. TennCare is a demonstration program under a Section 1115 waiver granted by the Centers for Medicare and Medicaid Services, ("CMS"). For the six months ended December 31, 2010, approximately 31% of the net patient service revenue of the Obligated Group was derived from the Medicare program and approximately 10% of the Obligated Group's net patient service revenue was derived from the combined Medicaid and TennCare programs.

Medicare

Medicare is a federal governmental health insurance system under which physicians, hospitals and other health care providers are reimbursed or paid directly for services provided to eligible elderly and disabled persons and persons with end-stage renal disease. Medicare is administered by CMS. In order to achieve and maintain Medicare certification, a health care provider must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the state in which the provider is located and/or The Joint Commission ("The Joint Commission") or the Healthcare Facilities Accreditation Program. The federal government frequently revises the laws, regulations and policies governing Medicare eligibility, coverage, payment and participation under the Medicare program. At this time, it is not known whether future changes to such laws, regulations or policies will have a material adverse financial effect on the Obligated Group.

The Obligated Group depends significantly on Medicare as a source of revenue. Because of this dependence, changes in the Medicare program may have a material effect on the Obligated Group. Future reductions in Medicare reimbursement, or increases in Medicare reimbursement in amounts less than increases in the costs of providing care, may have a material adverse financial effect on the Obligated Group.

A substantial portion of the Medicare revenues of the Obligated Group is derived from payments made for services rendered to Medicare beneficiaries under a prospective payment system, or PPS. Under a prospective payment system, the amount paid to the provider for an episode of care is established by federal regulation and is not related to the provider's charges or costs of providing that care. Presently, inpatient and outpatient services, skilled nursing care, and home health care are paid on the basis of a prospective payment system. Under inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient's assigned diagnosis related group, or DRG. DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. All services paid under the PPS for hospital outpatient services are classified into groups called ambulatory payment classifications, or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. The capital component of care is paid on a fully prospective basis.

PPS-exempt hospitals and units (inpatient psychiatric, rehabilitation and long-term hospital services) are currently reimbursed for their reasonable costs, subject to a cost per discharge target. These limits are updated annually by an index generally based upon inflationary increases in costs of providing health care services.

From time to time, the factors used in calculating the prospective payments for units of service are modified by CMS, which may reduce revenues for particular services. Additionally, as part of the federal budgetary process, Congress has regularly amended the Medicare law to reduce increases in payments that are otherwise

scheduled to occur, or to provide for reductions in payments for particular services. These actions could adversely affect the revenues of the Obligated Group.

In the Prospective Payment Final Rule for 2008 and in the Prospective Payment Final Rule for 2009 (together, the "IPPS Rules"), CMS included provisions preventing hospitals from assigning patient cases to DRGs with higher payments where a secondary diagnosis warranting higher payment is one of several specified health conditions and was acquired in the hospital. Specifically, the IPPS Rules identify certain conditions, including certain infections and serious preventable errors ("never events"), for which CMS will not reimburse hospitals unless the conditions were present at the time of admission. CMS has also announced its intent to identify additional conditions for which higher payment will be unavailable. Various HMOs and other private insurers have followed suit in refusing to pay for certain hospital-acquired conditions. There can be no assurance that these future payment limitations will not adversely affect the revenues of the Obligated Group. Never events may be more likely to be publicized and may negatively impact a hospital's reputation, thereby reducing future utilization and potentially increasing the possibility of liability claims.

Additional payments may be made to individual providers. Hospitals that treat a disproportionately large number of low-income patients (Medicaid and Medicare patients eligible to receive supplemental Social Security income) currently receive additional payments in the form of disproportionate share payments. Additional payments are made to hospitals that treat patients who are costlier to treat than the average patient; these additional payments are referred to as "outlier payments." Eligible hospitals are paid for a portion of their direct and indirect medical education costs. These additional payments are also subject to reductions and modifications in otherwise scheduled increases as a result of amendments to relevant statutory provisions.

The costs of providing a unit of care may exceed the revenues realized from Medicare for providing that service. Additionally, the aggregate costs to a provider of providing care to Medicare beneficiaries may exceed aggregate Medicare revenues received during the relevant fiscal period.

Medicare Audits. Hospitals participating in Medicare are subject to audits and retroactive audit adjustments with respect to reimbursements claimed under the Medicare program. The Members of the Obligated Group receive payments for various services provided to Medicare patients based upon charges or other reimbursement methodologies that are then reconciled annually based upon the preparation and submission of annual cost reports. Estimates for the annual cost reports are reflected as amounts due to/from third-party payors and represent several years of open cost reports due to time delays in the fiscal intermediaries' audits and the basic complexity of billing and reimbursement regulations. These estimates are adjusted periodically based upon correspondence received from the fiscal intermediary. Medicare regulations also provide for withholding Medicare payment in certain circumstances if it is determined that an overpayment of Medicare funds has been made. In addition, under certain circumstances, payments 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 Members of the Obligated Group to civil or criminal sanctions. Management of the Corporation is not aware of any situation whereby a material Medicare payment is being withheld from the Members of the Obligated Group.

CMS enlists Recovery Audit Contractors ("RACs") to further assure accurate payments to providers. RACs search for potentially improper Medicare payments from prior years that may not have been detected through CMS's existing program integrity efforts. RACs are private contractors, paid on a contingency fee basis and use their own software and review processes to determine areas for review. Once a RAC identifies a potentially improper claim as a result of an audit, it applies an assessment to the provider's Medicare reimbursement in an amount estimated to equal the overpayment from the provider pending resolution of the audit. Such audits may result in reduced reimbursement for past alleged overpayments and may slow future Medicare payments to providers pending resolution of appeals process with RACs. Under the Health Care Reform Act, recovery audits were expanded to include Medicaid by requiring states to contract with RACs to conduct such audits. It is unknown what, if any, future impact such reviews will have on the revenues of the Obligated Group. See the caption, "Health Care Reform," above for changes to the Medicare program in the Health Care Reform Act.

Medicaid

Tennessee Medicaid Alternative. Effective January 1, 1994, Tennessee implemented a healthcare program as an alternative to traditional Medicaid called TennCare. The principal elements of TennCare that distinguish it from Medicaid include: eligibility standards, the nature and content of the standard benefit package, the organization of health services delivery, the methodology of payment and requirement for global budgeting, and preventive care features.

Medicare waiver programs such as TennCare are time-limited, and TennCare's current waiver is set to expire on June 30, 2013 unless it is renewed.

The current TennCare program consists of two programs: (1) TennCare Medicaid, which is for persons who are Medicaid eligible, and (2) TennCare Standard, which is for persons who are not Medicaid eligible but who have been determined to meet the state's criteria as being either uninsured or uninsurable. Historically, individuals in both programs have received the same services. TennCare Standard enrollees with family incomes at or above poverty are required to pay premiums and copays.

TennCare services are offered through several managed care entities. Each enrollee has a Managed Care Organization (MCO) for his primary care and medical/surgical services, a Behavioral Health Organization (BHO) for his mental health and substance abuse treatment services, and a Pharmacy Benefits Manager (PBM) for his pharmacy services. Children under the age of 21 are eligible for dental services, which are provided by a Dental Benefits Manager (DBM). Enrollees are allowed to choose the MCO they wish from among those available in the areas in which they live.

MCOs have traditionally been compensated based on a per member, per month capitation fee for each enrollee, regardless of how many services the enrollee used. However beginning in July 2002, TennCare began utilizing an Administrative Services Only ("ASO") compensation structure. The ASO structure requires MCOs to submit invoices to TennCare for payment of medical services delivered in order to receive a fixed administrative fee.

Because TennCare includes quality monitoring as well as efficiency monitoring, together with limitations on payments, it is expected to cause downward pressure on the economics of healthcare delivery. In addition, TennCare limits payments for educational services, such as those offered by medical schools. Furthermore, funding for hospitals in urban areas which deliver higher levels of acute care may not be adequate to meet the needs of such hospitals. It cannot be predicted whether the funding sources for TennCare will be adequate to meet the funding needs of the program; therefore, if TennCare utilization increases, the financial performance of the providers will be adversely affected. In fiscal year 2010 the Obligated Group received approximately 6% of its gross patient revenues from the treatment of TennCare inpatients and outpatients.

The management of the Obligated Group estimates that the System is paid approximately 60-70 cents on each dollar spent to care for TennCare and Medicaid patients. Treatment of TennCare and Medicaid patients accounted for 13% of the Obligated Group's gross patient service revenues for the fiscal year ended June 30, 2010.

Payments for services provided by the Corporation and the Obligated Group to TennCare beneficiaries are the sole responsibility of the managed care organizations contracting for such services. No assurance can be given that the managed care organizations will be financially able to pay all amounts owed the Corporation or that such amounts will be timely paid.

State Children's Health Insurance Program

The State Children's Health Insurance Program ("SCHIP") is a federally funded insurance program for families which are financially ineligible for Medicaid, but cannot afford commercial health insurance. The CMS administers SCHIP, but each state creates its own program based upon minimum federal guidelines. SCHIP insurance is provided through private health plans contracting with the state.

Each state must periodically submit its SCHIP plan to CMS for review to determine if it meets the federal requirements. If it does not meet the federal requirements, a state can lose its federal funding for the program.

Private Health Plans and Managed Care

Managed care plans generally use discounts and other economic incentives to reduce or limit the cost and utilization of health care services. Payments to the Obligated Group from managed care plans typically are lower than those received from traditional indemnity/commercial insurers. Defined broadly, for the six months ended December 31, 2010, managed care payments constituted approximately 35% of the net patient service revenues of the Obligated Group. There is no assurance that the members of the Obligated Group will maintain managed care contracts or obtain other similar contracts in the future. Failure to maintain contracts could have the effect of reducing the market share of a member of the Obligated Group and the Obligated Group's net patient services revenues. Conversely, participation may maintain or increase the patient base but could result in lower net income or operating losses to the Obligated Group if the members are unable to adequately contain their costs.

The Corporation's management anticipates that the Health Care Reform Act will substantially alter the commercial health care insurance industry. The Health Care Reform Act imposes, over time, increased regulation of the industry, the use and availability of state-based exchanges in which health insurance can be purchased by certain groups and segments of the population, the extension of subsidies and tax credits for premium payments by some consumers and employers and the imposition upon commercial insurers of certain terms and conditions that must be included in contracts with providers. In addition, the Health Care Reform Act imposes many new obligations on states related to health care insurance. It is unclear how the increased federal oversight of state health care may affect future state oversight or affect the Corporation and the other Members of the Obligated Group. The effects of these changes upon the financial condition of any third-party payor that offer health care insurance, rates paid by third-party payors to providers and thus the revenues of the Obligated Group, and upon the operations, results of operations and financial condition of the Obligated Group cannot be predicted.

Many preferred provider organizations, or PPOs, and health maintenance organizations, or HMOs, currently pay providers on a negotiated fee-for-service basis or on a fixed rate per day of care, which, in each case, usually is discounted from the typical charges for the care provided. The discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a hospital may vary significantly from projections, and/or changes in the utilization of certain services offered by the provider may be dramatic and unexpected, thus further jeopardizing the provider's ability to contain costs.

Some HMOs employ a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care at a particular hospital. In a capitation payment system, the hospital assumes a financial risk for the cost and scope of care given to the HMO's enrollees. In some cases, the capitated payment covers total hospital patient care provided. However, if payment under an HMO or PPO contract is insufficient to meet the hospital's costs of care or if utilization by enrollees materially exceeds projections, the financial condition of the hospital could erode rapidly and significantly.

As a consequence of the above factors, the effect of managed care on the Obligated Group's financial condition is difficult to predict and may be different in the future than the financial statements for the current periods reflect.

Dependence Upon Third-Party Payors

The Obligated Group Members' ability to develop and expand their services and, therefore, profitability, is dependent upon their ability to enter into contracts with third-party payors at competitive rates. There can be no assurance that they will be able to attract third-party payors, and where they do, no assurance can be given that they will be able to contract with such payors on advantageous terms. The inability of the Obligated Group Members to contract with a sufficient number of such payors on advantageous terms could have a material adverse effect on the Obligated Group Members' future operations and financial results.

Alternative or Integrated Delivery System Development

Many hospitals and health systems are pursuing strategies with physicians in order to offer an integrated package of health care services, including physician and hospital services, to patients, health care insurers and managed care providers. The Health Care Reform Act encourages the development of health care delivery models that are designed to enhance quality and reduce cost and that will effectively require greater integration between and collaboration among hospitals and physicians by allowing accountable care organizations ("ACOs") that meet quality thresholds to share in the savings achieved for the Medicare Program. The Health Care Reform Act requires the Secretary of HHS to implement a shared savings program through ACOs requiring integration between hospitals and physicians, that will deliver health care services to Medicare beneficiaries, and to implementation a demonstration project to develop ACOs for pediatric patients under the Medicaid program.

In addition to ACOs, these integration strategies may take many forms, including management service organizations, or MSOs, which may provide physicians or physician groups with a combination of financial and managed care contracting services, office and equipment, office personnel and management information systems. Integration objectives may also be achieved via physician-hospital organizations, or PHOs, organizations which are typically jointly owned or controlled by a hospital and physician group for the purpose of managed care contracting, implementation and monitoring. Other integration structures include hospital-based clinics or medical practice foundations, which may purchase and operate physician practices as well as provide all administrative services to physicians. Many of these integration strategies are capital intensive and may create certain business and legal liabilities for the related hospital or health system.

Often the start-up capitalization for such developments, as well as operational deficits, are funded by the sponsoring hospital or health system. Depending on the size and organizational characteristics of a particular development, these capital requirements may be substantial. In some cases, the sponsoring hospital or health system may be asked to provide a financial guarantee for the debt of a related entity which is carrying out an integrated delivery strategy. In certain of these structures, the sponsoring hospital or health system may have an ongoing financial commitment to support operating deficits, which may be substantial on an annual or aggregate basis.

These types of integrated delivery developments are generally designed to conform to existing trends in the delivery of medicine, to implement anticipated aspects of health care reform, to increase physician availability to the community and/or enhance the managed care capability of the affiliated hospital and physicians. However, these goals may not be achieved, and, if the development is not functionally successful, it may produce materially adverse results that are counterproductive to some or all of the above-stated goals.

All such integrated delivery developments carry with them the potential for legal or regulatory risks in varying degrees. Such developments may call into question compliance with the Medicare fraud and abuse laws, relevant antitrust laws and federal or state tax exemption. Such risks will turn on the facts specific to the implementation, operation or future modification of any integrated delivery system. MSOs which operate at a deficit over an extended period of time may raise significant risks of investigation or challenge regarding the tax-status of health care providers participating in MSOs or compliance with the Medicare fraud and abuse laws. In addition, depending on the type of development, a wide range of governmental billing and other issues may arise, including questions of the authorization of the entity to bill for or on behalf of the physicians involved. Other related legal and regulatory risks may arise, including employment, pension and benefits, and corporate practice of medicine, particularly in the current atmosphere of frequent and often unpredictable changes in federal and state legal requirements regarding health care and medical practice. The potential impact of any such regulatory or legal risks on the Obligated Group Members cannot be predicted with certainty. There can be no assurance that such issues and risks will not lead to material adverse consequences in the future.

Regulatory Environment

Licensing, Surveys, Investigations and Audits

Health facilities, including those of the Obligated Group, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements relating to Medicare Conditions of Participation, requirements for participation in Medicaid, state

licensing agencies, private payors and the accreditation standards of The Joint Commission. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews, some of which may require affirmative actions by a member of the Obligated Group.

The Corporation's management currently anticipates no difficulty renewing or continuing currently held licenses, certifications or accreditations, nor does management anticipate a reduction in third-party payments from events that would materially adversely affect the operations or financial condition of the Obligated Group. Nevertheless, actions in any of these areas could result in the loss of utilization or revenues, or the ability of a member of the Obligated Group to operate all or a portion of its health care facilities, and consequently, could have a material and adverse effect on the Obligated Group.

Certificates of Need

The State of Tennessee also administers a similar health planning program which includes certificate of need ("CON") requirements. The CON program requires that capital expenditures above certain limits or the introduction of new health services by or on behalf of a hospital first be approved by the Tennessee Health Facilities Commission before the expenditures are incurred or the new services are initiated. If a hospital desires to undertake a project involving capital expenditures above the limits or to add new health services, there can be no assurance that the expenditure will be granted CON approval. Amendments to or the repeal of the existing CON program could result in the entry of additional providers of healthcare services in the Corporation's and the Obligated Group's service area, thereby increasing competition and thus possibly reducing the demand for the Corporation's and the Obligated Group's services.

Negative Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures

Health plans, Medicare, Medicaid, TennCare, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and physicians. Published rankings such as "score cards," "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and the members of their medical staffs and to influence the behavior of consumers and providers such as the Obligated Group Members. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance set by others that characterize a hospital negatively may adversely affect its reputation and financial condition.

Civil and Criminal Fraud and Abuse Laws and Enforcement

Federal and state health care fraud and abuse laws regulate both the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to beneficiaries. Under these laws, individuals and organizations can be penalized for submitting claims for services that are not provided, billed in a manner other than as actually provided, not medically necessary, provided by an improper person, accompanied by an illegal inducement to utilize or refrain from utilizing a service or product, or billed in a manner that does not otherwise comply with applicable government requirements.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate healthcare fraud and abuse, including exclusion of the provider from participation in the Medicare/TennCare/Medicaid programs, fines, civil monetary penalties, and suspension of payments and, in the case of individuals, imprisonment. Fraud and abuse may be prosecuted by one or more government entities and/or private individuals, and more than one of the available penalties may be imposed for each violation.

Laws governing fraud and abuse apply to all individuals and healthcare enterprises with which a hospital does business, including other hospitals, home health agencies, long term care entities, infusion providers, pharmaceutical providers, insurers, health maintenance organizations, preferred provider organizations, third party administrators, physicians, physician groups, and physician practice management companies. Fraud and abuse

prosecutions can have a catastrophic effect on a provider and potentially a material adverse impact on the financial condition of other entities in the healthcare delivery system of which that entity is a part.

Based upon the prohibited activity in which the provider has engaged, governmental agencies and officials may bring actions against providers under civil or criminal False Claims Acts, statutes prohibiting referrals for compensation (including the federal "Anti-Kickback Law") or fee-splitting, or the "Stark law," which prohibits certain referrals by a physician to certain organizations in which the physician has a financial relationship, unless an exception applies. Many States also have self-referral prohibitions. The civil and criminal monetary assessments and penalties arising out of such investigations and prosecutions may be substantial. Additionally, the provider may be denied participation in the Medicare, TennCare and/or Medicaid programs. If and to the extent any member of the Obligated Group engaged in a prohibited activity and judicial or administrative proceedings concluded adversely to the member, the outcome could materially affect the Obligated Group.

On August 20, 2010, the Corporation filed a Report of Internal Investigation and Self-Assessment (the "Self Report") with the United States Attorney's Office in Southwest Virginia. This report was based upon the Corporation's discovery of certain issues involving office space at a Wellmont-owned medical office building at the Corporation's Lonesome Pine Hospital in Big Stone Gap, Virginia. The Corporation made certain office space in the medical office building available to certain members of the Lonesome Pine medical staff. Due to changes in personnel and miscommunications within the Corporation's internal office and administrative functions at Lonesome Pine Hospital, the billing procedures for such lease arrangements lapsed and certain physician groups were not billed for the applicable rent. The Corporation's investigation concluded that these circumstances were not intentional and were the result of oversights and lapses in internal communication.

Under applicable procedure, the United States Attorney's Office in Southwest Virginia advised the Office of Inspector General (the "OIG") of the Corporation's Self-Report. On October 21, 2010, the Corporation was advised that the OIG had accepted the Corporation's Self-Report into the OIG's Self-Report protocol. Subsequently, the Corporation and the OIG negotiated a complete resolution of the Self-Report. The resolution calls for the Corporation to make a settlement payment of approximately $250,000. The Corporation is awaiting the OIG's preparation of the necessary settlement documents for the Corporation's review and signature, at which time the required settlement payment will be made.

Tennessee has several anti-kickback and fee-splitting provisions, some of which apply on an all-payor basis (i.e., not just to governmental payors). Like the federal Anti-Kickback Statute, the Tennessee anti-kickback and fee-splitting provisions generally prohibit inducements or improper remuneration for the referral of patients. These Tennessee laws are broadly worded and generally have not been the subject of interpretation by Tennessee courts or by the Tennessee Attorney General. Therefore, it is difficult to predict the possibility or outcome of adverse enforcement action under these Tennessee laws.

Tennessee also has an all-payor physician self-referral law that prohibits physicians from referring patients to a healthcare entity in which the physician has an investment interest, unless an exception is met. Because the Tennessee physician self-referral law has been subject to limited judicial interpretation, it is difficult to predict the possibility or outcome of adverse enforcement action under this law.

The Health Care Reform Act authorizes the Secretary of HHS to exclude a provider's participation in Medicare, Medicaid and SCHIP as well as suspend payments to a provider pending an investigation of a credible allegation of fraud against the provider.

The Obligated Group Members have internal policies and procedures and have developed and implemented a compliance program that management believes will effectively reduce exposure for violations of these laws. However, because the government's enforcement efforts presently are widespread within the industry and may vary from region to region, there can be no assurance that the compliance program will significantly reduce or eliminate the exposure of the Obligated Group to civil or criminal sanctions or adverse administrative determinations.

False Claims Act

The False Claims Act, or FCA makes it illegal to submit or present a false, fictitious or fraudulent claim to the federal government and may include claims that are simply erroneous. FCA investigations and cases have become common in the health care field and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Violation or alleged violation of the FCA most often results in settlements that require multi-million dollar payments and compliance agreements. The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called "qui tam" actions. Qui tam plaintiffs, or "whistleblowers," share in the damages recovered by the government or recovered independently if the government does not participate. The FCA has become one of the government's primary weapons against health care fraud. FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on a hospital. A number of States, including Tennessee, have false claims laws in place that are comparable to the FCA.

Review of Outlier Payments

CMS is reviewing health care providers that are receiving large proportions of their Medicare revenues from outlier payments. Health care providers found to have obtained inappropriately high outlier payments will be subject to further investigation by the CMS Program Integrity Unit and potentially the Office of Inspector General. Management of the Corporation does not believe that any potential review of the Obligated Group Members would materially adversely affect the Obligated Group's results of operations.

Patient Records and Patient Confidentiality

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") addresses the confidentiality of individuals' health information. Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of the HIPAA statute and regulations or authorized by the patient. HIPAA's confidentiality provisions extend not only to patient medical records, but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions. These add costs and create potentially unanticipated sources of legal liability.

HIPAA imposes civil monetary penalties for violations and criminal penalties for knowingly obtaining or using individually identifiable health information. The penalties range from $50,000 to $250,000 and/or imprisonment if the information was obtained or used with the intent to sell, transfer or use the information for commercial advantage, personal gain or malicious harm.

The HITECH Act

Provisions in the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of H.R. 1, increase the maximum civil monetary penalties for violations of HIPAA and grant enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extends the reach of HIPAA beyond "covered entities," (ii) imposes a breach notification requirement on HIPAA covered entities, (iii) limits certain uses and disclosures of individually identifiable information and (iv) restricts covered entities' marketing communications.

The HITECH Act also established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified electronic health record ("EHR") technology. Beginning in 2011, the Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals for demonstrating meaningful use of certified EHR technology. Health care providers demonstrate their meaningful use of EHR technology by meeting objectives specified by the Centers for Medicare and Medicaid Services for using health information technology and by reporting on specified clinical quality measures. Beginning in 2015, hospitals and physicians who have not satisfied the performance and reporting criteria for demonstrating meaningful use will have their Medicare payments significantly reduced.

Security Breaches and Unauthorized Releases of Personal Information

Federal and state authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. Many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently damage a health care provider's reputation and materially adversely affect business operations.

Patient Transfers

A federal "anti-dumping" statute imposes certain requirements that must be met before transferring a patient to another facility. Failure to comply with the law can result in exclusion from the Medicare, TennCare and/or Medicaid programs as well as civil and criminal penalties. Failure of any Member of the Obligated Group to meet its responsibilities under the law could adversely affect the financial conditions of that Member.

The Corporation's management is not aware of any pending or threatened claim, investigation, or enforcement action regarding patient transfers that, if determined adversely to a Member of the Obligated Group, would have material adverse consequences to the Obligated Group.

Certain Business Transactions

Physician Relations

The primary relationship between a hospital and physicians who practice in it is through the hospital's organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may have his or her privileges or membership curtailed, denied or revoked. Physicians who are denied medical staff membership or certain clinical privileges, or who have membership or privileges curtailed, denied or revoked often file legal actions against hospitals. Such action may include a wide variety of claims, some of which could result in substantial uninsured damages to a hospital. In addition, failure of the hospital governing body to adequately oversee the conduct of the medical staff may result in hospital liability to third parties. All hospitals, including those owned and operated by the members of the Obligated Group, are subject to such risk.

Physician Contracting

The Members of the Obligated Group may contract with physician organizations (such as independent physician associations and physician-hospital organizations) to arrange for the provision of physician and ancillary services. Because physician organizations are separate legal entities with their own goals, obligations to shareholders, financial status, and personnel, there are risks involved in contracting with the physician organizations.

The success of the Obligated Group will be partially dependent upon its ability to attract physicians to join the physician organizations and to participate in their networks, and upon the ability of the physicians, including the employed physicians, to perform their obligations and deliver high quality patient care in a cost-effective manner. There can be no assurance that the members of the Obligated Group will be able to attract and retain the requisite number of physicians, or that physicians will deliver high quality health care services. Without paneling a sufficient . number and type of providers, the Obligated Group could fail to be competitive, could fail to keep or attract payor contracts, or could be prohibited from operating until its panel provided adequate access to patients. Such occurrences could have a material adverse effect on the business or operations of the Obligated Group.

Affiliations, Merger, Acquisition and Divestiture

The Obligated Group Members evaluate and pursue potential acquisition, merger and affiliation candidates as part of the overall strategic planning and development process. As part of its ongoing planning and property management functions, the Obligated Group reviews the use, compatibility and business viability of many of the operations of the members, and from time to time the members may pursue changes in the use of, or disposition of, their facilities. Likewise, members of the Obligated Group occasionally receive offers from, or conduct discussions with, third parties about the potential acquisition of operations and properties which may become subsidiaries or Affiliates of members of the Obligated Group in the future, or about the potential sale of some of the operations or property which are currently conducted or owned by the members. Discussion with respect to affiliation, merger, acquisition, disposition or change of use of facilities, including those which may affect the members, are held from time to time with other parties. These may be conducted with acute care hospital facilities and may be related to potential affiliation with a member of the Obligated Group. As a result, it is possible that the current organization and assets of the members may change from time to time.

In addition to relationships with other hospitals and physicians, the members of the Obligated Group may consider investments, ventures, affiliations, development and acquisition of other health care-related entities. These may include home health care, long-term care entities or operations, infusion providers, pharmaceutical providers, and other health care enterprises that support the overall operations of the members of the Obligated Group. In addition, the members of the Obligated Group may pursue transactions with health insurers, HMOs, preferred provider organizations, third-party administrators and other health insurance-related businesses. Because of the integration occurring throughout the health care field, management will consider these arrangements if there is a perceived strategic or operational benefit for the Obligated Group. Any initiative may involve significant capital commitments and/or capital or operating risk (including, potentially, insurance risk) in a business in which the members of the Obligated Group may have less expertise than in hospital operations. There can be no assurance that these projects, if pursued, will not lead to material adverse consequences to the Obligated Group.

Antitrust

Enforcement of antitrust laws against health care providers is becoming more common, and antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, third party contracting, physician relations, and joint venture, merger, affiliation and acquisition activities. While the application of federal and state antitrust laws to health care is still evolving, enforcement activities by federal and state agencies appear to be increasing. Violators of antitrust laws could be subject to criminal and civil liability by both federal and state agencies, as well as by private litigants.

Tax Matters

Tax Exemption for Not-For-Profit Corporations

Loss of tax-exempt status by an Obligated Group Member could result in loss of tax exemption of the Bonds and of other tax-exempt debt issued for the benefit of the Obligated Group Members, and defaults in covenants regarding the Bonds and other related tax-exempt debt would likely be triggered. Such an event would have material adverse consequences on the financial condition of the Obligated Group. Management of the Corporation is not aware of any transactions or activities currently ongoing that are likely to result in the revocation of the tax-exempt status of any Obligated Group Member.

The maintenance by each Obligated Group Member (other than Wellmont, Inc.) of its status as an organization described in Section 501(c)(3) of the Code is contingent upon compliance with general rules promulgated in the Code and related regulations regarding the organization and operation of tax-exempt entities, including their operation for charitable and educational purposes and their avoidance of transactions that may cause their assets to inure to the benefit of private individuals. The Internal Revenue Service has announced that it intends to closely scrutinize transactions between not-for-profit corporations and for-profit entities, and in particular has issued audit guidelines for tax-exempt hospitals. 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 Internal Revenue Service in the form of Private Letter Rulings, many activities have not been

addressed in any official opinion, interpretation or policy of the Internal Revenue Service. Because the Obligated Group Members conduct large-scale and diverse operations involving private parties, there can be no assurances that certain of their transactions would not be challenged by the Internal Revenue Service.

The Internal Revenue Service has taken the position that hospitals which are in violation of the Anti-Kickback Law may also be subject to revocation of their tax-exempt status. See the information herein under the caption, "RISK FACTORS - Regulatory Environment - Civil and Criminal Fraud and Abuse Laws and Enforcement." As a result, tax-exempt hospitals, such as those of the Obligated Group Members, which have, and will continue to have, extensive transactions with physicians are subject to an increased degree of scrutiny and perhaps enforcement by the Internal Revenue Service.

The Taxpayers Bill of Rights 2, referred to for purposes of this Official Statement as the Intermediate Sanctions Law, allows the Internal Revenue Service to impose "intermediate sanctions" against certain individuals in circumstances involving the violation by tax-exempt organizations of the prohibition against private inurement. Prior to the enactment of the Intermediate Sanctions Law, the only sanction available to the Internal Revenue Service was revocation of an organization's tax-exempt status. Intermediate sanctions may be imposed in situations in which a "disqualified person" (such as an "insider") (i) engages in a transaction with a tax-exempt organization on other than a fair market value basis, (ii) receives unreasonable compensation from a tax-exempt organization or (iii) receives payment in an arrangement that violates the prohibition against private inurement. These transactions are referred to as "excess benefit transactions." A disqualified person who benefits from an excess benefit transaction will be subject to an excise tax equal to 25% of the amount of the excess benefit. Organizational managers who participate in the excess benefit transaction knowing it to be improper are subject to an excise tax equal to 10% of the amount of the excess benefit, subject to a maximum penalty of $20,000. A second penalty, in the amount of 200% of the excess benefit, may be imposed on the disqualified person (but not upon the organizational manager) if the excess benefit is not corrected within a specified period of time.

In certain cases, the IRS has imposed substantial monetary penalties and future charity care or public benefit obligations on tax-exempt hospitals in lieu of revoking their tax-exempt status, as well as requiring that certain transactions be altered, terminated or avoided in the future and/or requiring governance or management changes. These penalties and obligations are typically imposed on the tax-exempt hospital pursuant to a "closing agreement" with respect to the hospital's alleged violation of Section 501(c)(3) exemption requirements. Given the size of the Obligated Group, the wide range of complex transactions entered into by the Obligated Group Members and uncertainty regarding how tax-exemption requirements may be applied by the IRS, Members are, and will be, at risk for incurring monetary and other liabilities imposed by the IRS through this "closing agreement" or similar process. Like certain of the other business and legal risks described herein which apply to large multi-hospital systems, these liabilities are probable from time to time and could be substantial, in some cases involving millions of dollars, and in extreme cases could be materially adverse.

Bills have been introduced in Congress that would require a tax-exempt hospital to provide a certain amount of charity care and care to Medicare and Medicaid patients in order to maintain its tax-exempt status and avoid the imposition of an excise tax. Other legislation would have conditioned a hospital's tax-exempt status on the delivery of adequate levels of charity care. Congress has not enacted such bills. However, there can be no assurance that similar legislative proposals or judicial actions will not be adopted in the future.

In recent years, the IRS and state, county and local taxing authorities have been undertaking audits and reviews of the operations of tax-exempt hospitals with respect to their exempt activities and the generation of unrelated business taxable income. The Obligated Group Members participate in activities that may generate unrelated business taxable income. Management of the Corporation believes it and the other Obligated Group Members have properly accounted for and reported unrelated business taxable income; nevertheless, an investigation or audit could lead to a challenge which could result in taxes, interest and penalties with respect to unreported unrelated business taxable income and in some cases could ultimately affect the tax-exempt status of a Obligated Group Member as well as the exclusion from gross income for federal income tax purposes of the interest payable on the Bonds and other tax-exempt debt of the Obligated Group Members. In addition, legislation, if any, which may be adopted at the federal, state and local levels with respect to unrelated business income cannot be predicted. Any legislation could have the effect of subjecting a portion of the income of the Obligated Group Members to federal or state income taxes.

Obligated Group Members have been, are being and most likely will be audited regularly by the IRS. Management believes that it has properly complied with the tax laws. Nevertheless, because of the complexity of the tax laws and the presence of issues about which reasonable persons can differ, an audit could result in additional taxes, interest and penalties. An audit could ultimately affect the tax-exempt status of a Obligated Group Member as well as the exclusion from gross income for federal income tax purposes of the interest payable with respect to the Bonds and other tax-exempt debt of the Obligated Group Members.

In addition to the foregoing proposals with respect to income by not-for-profit corporations, various state and local governmental bodies have challenged the tax-exempt status of not-for-profit institutions and have sought to remove the exemption of property from real estate taxes of part or all of the property of various not-for-profit institutions on the grounds that a portion of its 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 not-for-profit corporations. There can be no assurance that future changes in the laws and regulations of federal, state or local governments will not materially adversely affect the operations and financial condition of the Obligated Group Members by requiring any of them to pay income or local property taxes.

Tax-Exempt Status of the Bonds

The Code imposes a number of requirements that must be satisfied for interest on state and local obligations, such as the Bonds, to be excludable from gross income for federal income tax purposes. These requirements include limitations on the use of bond proceeds, limitations on the investment earnings of bond proceeds prior to expenditure, a requirement that certain investment earnings on bond proceeds be paid periodically to the United States, and a requirement that the issuers file an information report with the IRS. The Corporation has agreed that it will comply with such requirements. Failure to comply with the requirements stated in the Code and related regulations, rulings and policies may result in the treatment of the interest on the Bonds as taxable. Such adverse treatment may be retroactive to the date of issuance.

Bond Examinations

The IRS has added a new Schedule H to IRS Form 990, on which hospitals and health systems will be required to report how they provide community benefit and to specify certain billing and collection practices. The IRS has also added a new Schedule K to IRS Form 990. This new schedule requests detailed information related to all outstanding bond issues of nonprofit corporations, including, for bonds issued after 2002, information regarding operating, management and research contracts as well as private business use compliance. Filers must complete the entire schedule for tax years beginning in 2009.

Although the Corporation believes that its expenditure and investment of bond proceeds, use of property financed with tax-exempt debt and record retention practices comply with all applicable laws and regulations, there can be no assurance that an IRS review triggered by information submitted on a Schedule H or Schedule K would not adversely affect the market value of the Bonds or of other outstanding tax-exempt indebtedness of the Obligated Group. Additionally, the Bonds or other tax-exempt obligations issued for the benefit of the Obligated Group Members, may be, from time to time, subject to examinations by the IRS. The Corporation received a notice from the IRS dated January 26, 2011 to the effect that the Series 2005 Bonds had been selected for a routine examination to determine compliance with federal tax requirements, together with a Form 4564 Information Document Request requesting certain documentation relating to the Series 2005 Bonds. On March 15, 2011, the Corporation responded to such request providing the requested documentation. Such examination is ongoing. The Corporation believes that the Series 2005 Bonds and other tax-exempt obligations issued for the benefit of the Obligated Group Members properly comply with the tax laws. In addition, Bond Counsel rendered an opinion with respect to the tax-exempt status of the Bonds upon their issuance, as described under the caption "TAX STATUS." No ruling with respect to the tax-exempt status of the Bonds, has been or will be sought from the IRS, however, and the opinions of counsel are

not binding on the IRS or the courts. There can be no assurance that any IRS examination of the Bonds will not adversely affect the market value of the Bonds. See "TAX STATUS" below.

Other Risks

Indigent Care

Tax-exempt hospitals often treat large numbers of "indigent" patients who, for various reasons, are unable to pay for their medical care. Typically, urban, inner-city hospitals, including hospitals owned by certain Obligated Group Members, may treat significant numbers of indigents. These hospitals may be susceptible to economic and political changes which could increase the number of indigent persons or the responsibility for caring for this population. General economic conditions which affect the number of employed individuals who have health insurance coverage will similarly affect the ability of patients to pay for their care. Similarly, changes in governmental policy, which may result in coverage exclusions under local, state and federal healthcare programs (including Medicare and Medicaid) may increase the frequency and severity of indigent treatment in such hospitals. It is also possible that future legislation could require that tax-exempt hospitals maintain minimum levels of indigent care as a condition to federal income tax exemption or local property tax exemption. In sum, indigent care commitments of the Obligated Group Members could constitute a material and adverse financial risk in the future.

Cost of Capital

From time to time, Congress has considered and is considering revisions to the Internal Revenue Code that may prevent or limit access to the tax-exempt debt market to corporations or issuers such as the Obligated Group Members. Such legislation, if enacted into law, may have the effect of increasing the capital costs of the Obligated Group Members.

Interest Rate Swaps

The Corporation has entered into certain interest rate swap transactions with respect to its outstanding bonds. Under certain circumstances, the interest rate swap may be terminated prior to the maturity of the related outstanding bonds. If the interest rate swap is terminated under certain market conditions, the Corporation may owe a termination payment to the applicable swap counterparty. Such a termination payment generally would be based upon the market value of the related interest rate swap on the date of termination and could be substantial. In addition, a partial termination of an interest rate swap could occur to the extent that any outstanding bonds hedged with an interest rate swap is redeemed pursuant to an optional redemption. If such an optional redemption occurs, a termination payment related to the portion of the interest rate swap to be terminated will be owed by either the Corporation or the applicable swap counterparty, depending on market conditions. In the event of an early termination of an interest rate swap, there can be no assurance that (i) the Corporation will receive any termination payment payable to it by the applicable swap counterparty, (ii) the Corporation will have sufficient amounts to pay a termination payment payable by it to the applicable swap counterparty and (iii) the Corporation will be able to obtain a replacement swap agreement with comparable terms. The Corporation has credit risk to the extent the applicable swap counterparty's credit or ability to perform is reduced.

Bond Ratings

There is no assurance that the ratings assigned to the 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 Bonds. See the information herein under the caption "RATINGS."

Investments

Corporation has significant holdings in a broad range of investments. Market fluctuations have affected and may continue to affect the value of those investments. Those fluctuations may be at times material.

Staffing Shortages

From time to time, the healthcare industry has suffered from a scarcity of nursing and other qualified health care technicians and personnel. Staffing shortages could force the Obligated Group Members to pay higher salaries to nursing and other qualified health care technicians and personnel as competition for such employees intensifies and, in an extreme situation, could lead to difficulty in keeping the facilities licensed to provide nursing care and thus eligible for reimbursement under Medicare, TennCare and Medicaid.

Professional Liability Claims and Liability Insurance

In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased nationwide, resulting in substantial increases in malpractice insurance premiums. Professional liability and other actions alleging wrongful conduct and seeking punitive damages often are filed against health care providers. Litigation may also arise from the corporate and business activities of the Corporation and its affiliates, employee-related matters, medical staff and provider network matters and denials of medical staff and provider network membership and privileges. As with professional liability, many of these risks are covered by insurance, but some are not. For example, some antitrust claims, business disputes and workers' compensation claims are not covered by insurance or other sources and, in whole or in part, may be a liability of the Corporation and its affiliates if determined or settled adversely. Claims for punitive damages may not be covered by insurance under certain state laws. Although the Members of the Obligated Group currently maintain actuarially determined self-insurance reserves and carry excess malpractice and general liability insurance which management of the Corporation considers adequate, management of the Corporation is unable to predict the availability, cost or adequacy of such insurance in the future.

Other Risk Factors Generally Affecting Health Care Facilities

In the future, the following factors, among others, may adversely affect the operations of health care providers, including the Obligated Group Members or the market value of the Bonds, to an extent that cannot be determined at this time:

a. Hospitals 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 Obligated Group Members bear a wide variety of risks in connection with their 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 Obligated Group Members are subject to all of the risks listed above, and such risks, alone or in combination, could have material adverse consequences to the financial condition or operations of the Obligated Group.

b. Competition from other hospitals and other competitive facilities now or hereafter located in the respective service areas of the facilities operated by the Corporation and the Obligated Group Members may adversely affect revenues of the Obligated Group. 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 Obligated Group Members.

c. Cost and availability of any insurance, including self-insurance, such as malpractice, fire, automobile, and general comprehensive liability, that hospitals and other health care facilities of similar size and type as the Obligated Group Members generally carry may adversely affect revenues. The costs of such insurance have increased significantly in the past few years, and such increases are likely to continue in the near future.

d. The occurrences of natural disasters may damage some or all of the facilities, interrupt utility service to some or all of the facilities or otherwise impair the operation of some or all of the facilities operated by the Obligated Group Members or the generation of revenues from some or all of the facilities.

e. 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 Obligated Group Members to offer the equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance these acquisitions or operations.

f. Reduced demand for the services of the Obligated Group Members that might result from decreases in population in their respective service areas.

g. Increased unemployment or other adverse economic conditions in the service areas of the Obligated Group Members which would increase the proportion of patients who are unable to pay fully for the cost of their care.

h. Any increase in the quantity of indigent care provided which is mandated by law or required due to increased needs of the community in order to maintain the charitable status of the Obligated Group Members.

i. Regulatory actions which might limit the ability of the Obligated Group Members to undertake capital improvements to their respective facilities or to develop new institutional health services.

j. The occurrence of a large scale terrorist attack that increases the proportion of patients who are unable to pay fully for the cost of their care and that disrupts the operation of certain health care facilities by resulting in an abnormally high demand for health care services.

k. Instability in the stock market or other investment markets which may adversely affect both the principal value of, and income from, the Corporation's investment portfolio.

CONTINUING DISCLOSURE

The Corporation and the other Obligated Group members (collectively, the "Obligors") will enter into a continuing disclosure agreement (the "Continuing Disclosure Agreement") pursuant to the requirements of Rule 15c2-12 ("Rule 15c2-12") adopted by the Securities and Exchange Commission (the "SEC") under the Securities Exchange Act of 1934, as amended. The Continuing Disclosure Agreement will be entered into by the Obligors for the benefit of the beneficial owners of the Bonds and will obligate the Obligors to provide certain information annually and quarterly and to file notice of the occurrence of certain events. A summary of the Continuing Disclosure Agreement is included in APPENDIX E.

The Corporation serves as the parent organization for affiliated entities, including the members of the Obligated Group. The audited financial statements of the Corporation included in APPENDIX B are consolidated statements that provide financial information with respect to the Corporation and its affiliates described in the audit report, including the other Obligors. The Obligors do not have audited financial statements prepared for the Obligors alone. The Obligors intend to comply with their obligations under the Continuing Disclosure Agreement by continuing to provide audited annual financial statements substantially in the form presented in APPENDIX B.

The Obligors have represented that they are in compliance with all agreements previously entered into by them pursuant to Rule 15c2-12. A failure by the Obligors to comply with the Continuing Disclosure Agreement will not constitute an event of default under the Loan Agreement. Beneficial owners of the Bonds are limited to the remedies described in the Continuing Disclosure Agreement. A failure by the Issuer to comply with the Continuing

Disclosure Agreement must be reported in accordance with Rule 15c2-12 and must be considered by any broker, dealer or municipal securities dealer before recommending the purchase or sale of the Bonds in the secondary market. Consequently, such a failure may adversely affect the transferability and liquidity of the Bonds and their market price.

TAX STATUS

Opinion of Bond Counsel—Federal Income Tax Status of Interest

The opinion of McGuireWoods LLP, Richmond, Virginia, Bond Counsel, will state that, under current law, interest on the Bonds is excludable from gross income for purposes of federal income taxation and is not a specific item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations. For purposes of the alternative minimum tax imposed on corporations (as defined for federal income tax purposes under Section 56 of the Internal Revenue Code of 1986, as amended (the "Code")), interest on the Bonds must be included in computing adjusted current earnings. See "APPENDIX D – FORM OF APPROVING OPINION OF BOND COUNSEL".

Bond Counsel will express no opinion regarding other federal tax consequences arising with respect to the Bonds.

Bond Counsel's opinion speaks as of its date, is based on current legal authority and precedent, covers certain matters not directly addressed by such authority and precedent, and represents Bond Counsel's judgment as to the proper treatment of interest on the Bonds for federal income tax purposes. Bond Counsel's opinion does not contain or provide any opinion or assurance regarding the future activities of the Issuer or the Obligated Group or about the effect of future changes in the Code, the applicable regulations, the interpretation thereof or the enforcement thereof by the Internal Revenue Service (the "IRS"). The Issuer and the Corporation have covenanted, however, to comply with the requirements of the Code.

Reliance and Assumptions; Effect of Certain Changes

In delivering its opinion regarding the Bonds, Bond Counsel is relying upon (i) certifications of representatives of the Issuer and the Corporation and other parties as to facts material to the opinion, which Bond Counsel has not independently verified and (ii) the opinion of Hunter, Smith & Davis, LLP, Counsel for the Corporation, to be delivered in connection with the issuance of the Bonds, that the Corporation is an organization described in Section 501(c)(3) of the Code.

In addition, Bond Counsel is assuming continuing compliance with the Covenants (as hereinafter defined) by the Issuer and the Corporation. The Code and the regulations promulgated thereunder contain a number of requirements that must be satisfied after the issuance of the Bonds in order for interest on the Bonds to be and remain excludable from gross income for purposes of federal income taxation. These requirements include, by way of example and not limitation, the requirement that the Corporation maintain its status as an organization described in Section 501(c)(3) of the Code, restrictions on the use, expenditure and investment of the proceeds of the Bonds and the use of the property financed or refinanced by the Bonds, limitations on the source of the payment of and the security for the Bonds, and the obligation to rebate certain excess earnings on the gross proceeds of the Bonds to the Treasury of the United States (the "Treasury"). The Indenture, the Loan Agreement and the Tax Compliance Agreement contain covenants (the "Covenants") under which the Issuer and the Corporation have agreed to comply with such requirements. Failure by the Issuer or the Corporation to comply with their respective Covenants could cause interest on the Bonds to become includable in gross income for federal income tax purposes retroactively to their date of issue. In the event of noncompliance with the Covenants, the available enforcement remedies may be limited by applicable provisions of law and, therefore, may not be adequate to prevent interest on the Bonds from becoming includable in gross income for federal income tax purposes. Compliance by the Issuer with its respective Covenants does not require the Issuer to make any financial contribution for which it does not receive funds from the Issuer and the Corporation.

Certain requirements and procedures contained, incorporated or referred to in the Indenture, the Loan Agreement and the Tax Compliance Agreement, including the Covenants, may be changed and certain actions may be taken or omitted under the circumstances and subject to the terms and conditions set forth therein. Bond Counsel expresses no opinion concerning any effect on the excludability of interest on the Bonds from gross income for federal income tax purposes of any such subsequent change or action that may be made, taken or omitted upon the advice or approval of counsel other than Bond Counsel.

Certain Collateral Federal Tax Consequences

The following is a brief discussion of certain collateral federal income tax matters with respect to the Bonds. It does not purport to address all aspects of federal taxation that may be relevant to a particular owner thereof. Prospective purchasers of the Bonds, particularly those who may be subject to special rules, are advised to consult their own tax advisors regarding the federal tax consequences of owning or disposing of the Bonds.

Prospective purchasers of the Bonds should be aware that the ownership of tax-exempt obligations may result in collateral federal income tax consequences to certain taxpayers, including, without limitation, financial institutions, certain insurance companies, certain corporations (including S corporations and foreign corporations), certain foreign corporations subject to the "branch profits tax," individual recipients of Social Security or Railroad Retirement benefits, taxpayers who may be deemed to have incurred or continued indebtedness to purchase or carry tax-exempt obligations and taxpayers attempting to qualify for the earned income tax credit.

In addition, prospective purchasers should be aware that the interest paid on, and the proceeds of the sale of, tax-exempt obligations, including the Bonds, are in many cases required to be reported to the IRS in a manner similar to interest paid on taxable obligations. Additionally, backup withholding may apply to any such payments made after March 31, 2007 to any owner of a Bond who fails to provide an accurate Form W-9 Request for Taxpayer Identification Number and Certification, or a substantially identical form, or to any owner of a Bond who is notified by the IRS of a failure to report all interest and dividends required to be shown on federal income tax returns. The reporting and withholding requirements do not in and of themselves affect the excludability of interest on the Bonds from gross income for federal tax purposes or any other federal tax consequence of purchasing, holding or selling tax-exempt obligations.

Possible Legislative or Regulatory Action

Legislation and regulations affecting tax-exempt bonds are continually being considered by the United States Congress, the Treasury and the IRS. In addition, the IRS has established an expanded audit and enforcement program for tax-exempt bonds. There can be no assurance that legislation enacted or proposed after the date of issue of the Bonds or an audit initiated or other enforcement or regulatory action taken by the Treasury or the IRS involving either the Bonds or other tax-exempt obligations will not have an adverse effect on the tax status or the market price of the Bonds or on the economic value of the tax-exempt status of the interest thereon.

Opinion of Bond Counsel — Tennessee Income Tax Consequences

In the opinion of Bond Counsel, under existing law, the Bonds and the interest thereon are exempt from all State of Tennessee state, county and municipal taxation except for inheritance, transfer and estate taxes and except to the extent that the Bonds and the interest thereon are included within the measure of certain privilege and excise taxes imposed under Tennessee law.

Bond Counsel will express no opinion regarding (i) other Tennessee tax consequences arising with respect to the Bonds or (ii) any consequences arising with respect to the Bonds under the tax laws of any state or local jurisdiction other than Tennessee. Prospective purchasers of the Bonds should consult their own tax advisors regarding state and local tax issues not covered by Bond Counsel's opinion, including the tax status of interest on the Bonds in a particular state or local jurisdiction other than Tennessee.

LEGAL COUNSEL

McGuireWoods LLP, Richmond, Virginia has served as bond counsel to the Corporation with respect to the issuance of the Bonds. Bond counsel will render an opinion with respect to the Bonds in substantially the form attached as APPENDIX D. The opinion of bond counsel should be read in its entirety for a complete understanding of the scope of the opinion and the conclusions expressed. Delivery of the Bonds is contingent upon the delivery of the opinion of bond counsel.

In connection with the issuance of the Bonds, Penn, Stuart & Eskridge, A Professional Corporation, Bristol, Tennessee, has served as counsel to the Issuer, Hunter, Smith & Davis, LLP, Kingsport, Tennessee, has served as counsel to the Corporation and the Obligated Group, and Presley Burton & Collier, LLC, Birmingham, Alabama, has served as counsel to the Underwriter.

INDEPENDENT AUDITORS

The consolidated financial statements of the Corporation as of June 30, 2010 and June 30, 2009 and for the years then ended, included in APPENDIX B to this Official Statement, have been audited by KPMG LLP, independent auditors, as stated in their report included in APPENDIX B.

LITIGATION

To the best of the Issuer's knowledge, there is no litigation pending or threatened (i) restraining or enjoining the issuance or delivery of the Bonds, (ii) contesting or affecting the validity of the Bonds or the proceedings or authority under which they are to be issued, (iii) contesting the creation, organization or existence of the Issuer or the title of any of its present officials to their respective offices, or (iv) contesting the right of the Issuer to enter into the Financing Documents to which it is a party or to secure the Bonds in accordance with the Indenture.

To the best of the Corporation's knowledge, there is no litigation pending or threatened regarding the matters described in the preceding paragraph. For a description of litigation pending against the Corporation and the Obligated Group, see APPENDIX A.

RATINGS

The following ratings have been assigned to the Bonds based on an assessment by each rating agency of the Obligated Group's ability to make payments on the Bonds:

Rating Agency	Rating Assigned
S & P	BBB+
Fitch	BBB+

Any further explanation as to the significance of these ratings may be obtained only from the appropriate rating agency. There is no assurance that any such rating will remain in effect for any given period of time or that the rating will not be revised downward or withdrawn entirely by the rating agency furnishing the same, if, in its judgment, the circumstances so warrant. Any such downward revision or withdrawal of a rating may have an adverse effect on the market price of the Bonds. The above ratings are not recommendations to buy, sell or hold the Bonds.

UNDERWRITING

Merrill Lynch, Pierce, Fenner & Smith Incorporated (the "Underwriter"), will enter into a bond purchase agreement in which the Underwriter will agree to purchase the Bonds, subject to certain conditions precedent, at a purchase price of $75,934,587.50 (face amount less underwriter's discount of $230,412.50). The Underwriter will

purchase all of the Bonds if any are purchased. The Underwriter has arranged for the purchase of the Bonds by its affiliate, Bank of America, N.A. (the "Initial Purchaser"). The Initial Purchaser will have the right to sell or distribute the Bonds or interests therein to subsequent purchasers or investors. Under the bond purchase agreement, the Corporation will agree to indemnify the Underwriter against certain costs, claims and liabilities, including certain liabilities arising under the Securities Act of 1933.

FINANCIAL ADVISOR

Ponder & Co. was engaged by the Corporation to provide financial advisory services in connection with the issuance of the Bonds. Ponder & Co. is a national consulting firm that acts as financial advisor to health care organizations in matters of capital formation, including debt financing, interest rate swaps and strategic capital planning.

RELATED PARTIES

Hunter, Smith & Davis, LLP, counsel to the Corporation and the Obligated Group, is regular counsel to the Issuer on matters unrelated to the Corporation and Obligated Group. McGuireWoods LLP, bond counsel, also represents the Trustee, the Master Trustee and the Underwriter in unrelated transactions.

MISCELLANEOUS

Neither this Official Statement nor any advertisement of the Bonds is to be construed as a contract or agreement with the holders of the Bonds. The agreement of the Issuer, the Corporation and the Obligated Group with the holders of the Bonds is fully set forth in the Bonds and the Financing Documents.

No dealer, broker, salesman or other person has been authorized by the Issuer or the Obligated Group to give any information or to make any representation other than as contained in this Official Statement, and, if given or made, such other information or representation must not be relied upon as having been authorized by them.

This Official Statement does not constitute an offer to sell or the solicitation of an offer to buy, nor shall there be any sale of the Bonds by any person in any jurisdiction in which it is unlawful for such person to make such offer, solicitation or sale.

The Bonds have not been registered under The Securities Act of 1933, as amended, or any state securities laws, and neither the Securities and Exchange Commission nor any state regulatory agency will pass upon the accuracy, completeness or adequacy of this Official Statement. Neither the Indenture nor the Master Indenture has been qualified under the Trust Indenture Act of 1939, as amended.

The information in this Official Statement is provided as of the date of this Official Statement. Nothing contained in this Official Statement shall under any circumstances create an implication that there has been no change in such information after the date of this Official Statement.

The information set forth in this Official Statement has been obtained from the sources which are deemed to be reliable but is not guaranteed as to accuracy or completeness. All estimates and assumptions contained herein are believed to be reliable, but no representation is made that such estimates or assumptions are correct or will be realized.

Certain statements contained in this Official Statement reflect forecasts and forward-looking statements, rather than historical facts. In this respect, the words "estimate," "project," "anticipate," "expect," "intend," "believe," and similar expressions are intended to identify forward-looking statements. All such forward-looking statements are expressly qualified by the cautionary statements set forth in this Official Statement.

The summaries and explanations of the provisions of the Bonds and the Financing Documents do not purport to be complete, and reference is made to the pertinent provisions of the Bonds and the Financing Documents

for a complete statement of their provisions. Such documents are on file and available for review during regular business hours upon request at the corporate trust offices of the Trustee, The Bank of New York Mellon Trust Company, N.A., Corporate Trust Services, 900 Ashwood Parkway, Suite 425, Atlanta, Georgia 30338.

In connection with this offering, the Underwriter may engage in transactions that stabilize, maintain or otherwise affect the price of the Bonds. Such transactions may include purchases of the Bonds for the purpose of maintaining the price of the Bonds. Such transactions, if commenced, may be discontinued at any time.

The attached appendices are integral parts of this Official Statement and must be read together with all of the foregoing statements.

APPROVAL OF USE OF OFFICIAL STATEMENT

The delivery of this Official Statement has been duly authorized by the Issuer and the Obligated Group.

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APPENDIX A.

INFORMATION REGARDING THE OBLIGATED GROUP

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APPENDIX A

INFORMATION CONCERNING WELLMONT HEALTH SYSTEM

The information contained in this Appendix A to this Official Statement has been obtained from Wellmont Health System

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INTRODUCTION

Overview

Wellmont Health System ("Wellmont") is a Tennessee non-profit corporation based in Kingsport, Tennessee and a premier provider of healthcare services in Northeast Tennessee and Southwest Virginia. Wellmont was formed in July 1996 with the merger of Bristol Memorial Hospital in Bristol, Tennessee and Holston Valley Medical Center in Kingsport, Tennessee. Over the past decade, Wellmont has grown to include six additional hospitals, an integrated physician network and several ambulatory sites. Wellmont hospitals offer a broad scope of services ranging from community-based acute care to highly specialized tertiary services including two trauma centers, comprehensive heart care and cancer care.

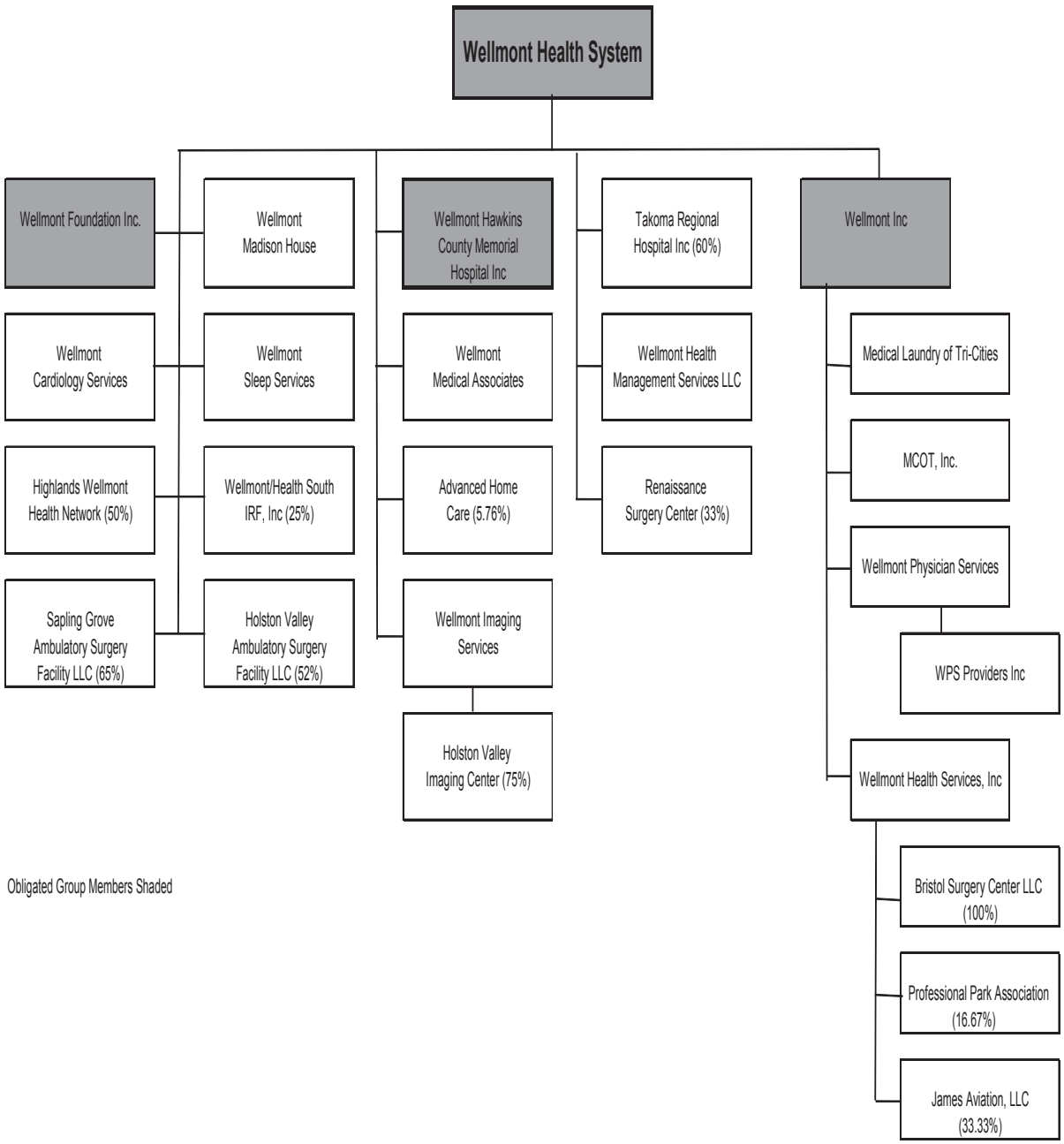
Wellmont owns and operates an integrated health care delivery system providing inpatient, outpatient and other health care services at multiple locations in Northeast Tennessee and Southwest Virginia. Currently, Wellmont owns and operates six acute care hospital facilities and one critical access hospital with a total of 1,253 licensed beds and, through a joint venture, partners to operate an additional acute care hospital facility with 100 licensed beds. The acute care facilities owned by Wellmont include Holston Valley Medical Center, Bristol Regional Medical Center, Mountain View Regional Medical Center in Norton, Virginia, Lee Regional Medical Center in Pennington Gap, Virginia, Lonesome Pine Hospital in Big Stone Gap, Virginia, Hawkins County Memorial Hospital in Rogersville, Tennessee and the critical access hospital, Hancock County Hospital in Sneedville, Tennessee. Wellmont is the majority partner with Adventist Health System at Takoma Regional Hospital, an acute care hospital in Greeneville, Tennessee.

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. Wellmont and such other entities, as set forth in the organizational chart below, are sometimes collectively referred to in this Appendix A as the "Health System." In addition to the hospital campuses and ambulatory care centers described above, the Health System also operates medical clinics, ambulatory surgery centers, comprehensive cancer care centers, and imaging facilities as further described herein.

Organization

Obligated Group

Wellmont is a member of the Obligated Group (as defined in Appendix C) under the Master Indenture (as defined in Appendix C). The other members of the Obligated Group include Wellmont Hawkins County Memorial Hospital, Inc. ("WHCMH"), Wellmont, Inc. ("Wellmont, Inc."), Wellmont Foundation (the "Foundation") and each other Person (as defined in Appendix C) who becomes a member of the Obligated Group in accordance with the Master Indenture. The Corporation, WHCMH, Wellmont, Inc. and the Foundation are hereinafter in this Appendix A referred to as the Obligated Group. For the fiscal year ended June 30, 2010, the Obligated Group accounted for 89.4% of the System's total net assets, 87.6% of its operating revenues and 64.7% of its operating income. For financial reporting purposes, the results of operations of System affiliates are consolidated with the results of operations of Members of the Obligated Group. It should be noted that given the subsidiary structure of the Corporation, the assets and associated revenues of the unobligated entities are essentially accessible to support debt of the organization.



Obligated Group Members Shaded

FACILITIES

Hospital Campuses

The Health System is licensed to operate 1,253 inpatient beds and, as of December 31, 2010, operated 804 acute care, critical care, psychiatric and rehab beds, 8 hospice beds and 44 long term care beds. The complement of available beds as of December 31, 2010 was as follows:

Available Bed Complement
As of December 31, 2010

	Acute Care	Critical Care	Psychiatric	Rehab	Hospice	Long Term Care	Total
Bristol Regional Medical Center	183	29	26		8		246
Holston Valley Medical Center	258	60					318
Mountain View Regional Medical Center	50	4				44	98
Lee Regional Medical Center	52	6					58
Lonesome Pine Hospital	51	6					57
Hawkins County Memorial Hospital	25	4					29
Hancock County Hospital	10						10
Wholly-owned	**629**	**109**	**26**	**0**	**8**	**44**	**816**
Takoma Regional Hospital	20		10	10			40
TOTAL	**649**	**109**	**36**	**10**	**8**	**44**	**856**

Bristol Regional Medical Center. Bristol Regional Medical Center, founded in 1925, operates in a state-of-the-art facility that opened in January 1994. The 348-bed facility is situated on a 125-acre campus with easy interstate access. Bristol Regional is staffed by 314 board-certified physicians and 1,779 employees. Centers of excellence include the Wellmont CVA Heart Institute, the J.D. and Lorraine Nicewonder Cancer Center, the Primary Stroke Center, cardiac care, a diabetes treatment center, an emergency department and Level II trauma center, inpatient and outpatient hospice care, neuroscience, occupational health, outpatient services, psychiatric care, rehabilitation services, women's health and a Level II neonatal intensive care unit. Bristol Regional was the first hospital in the Southeast to offer CyberKnife radiosurgery for the treatment of cancer and other tumors, and it has recently augmented its robotics program with the Da Vinci Robotic Surgery System.

Holston Valley Medical Center. Holston Valley Medical Center has been located in the Kingsport community since 1935. The 505-bed facility is staffed by 439 board-certified physicians and 2,120 employees. Centers of excellence include the Wellmont CVA Heart Institute, the Christine LaGuardia Phillips Cancer Center, a Level I trauma center (one of six in Tennessee), the Holston Valley Regional Children's Hospital including a Level III neonatal intensive care unit and pediatric intensive care, Madison House, a 27-bed assisted living and adult day care facility, a diabetes treatment center, neuroscience services, outpatient services, rehabilitation services and women's health. Thompson Reuters has named Holston Valley among its top 50 Heart Hospitals in the United States for 2011 and Holston Valley has been ranked Number 1 in Tennessee for cardiology for two years in a row by HealthGrades. Additionally, Holston Valley is the recipient of the 2011 HealthGrades Coronary Intervention Excellence Award™ and is ranked among the top ten percent in the nation for coronary interventional procedures in 2011. In fact, Holston Valley has been five-star rated for coronary interventional procedures two years in a row, five-star rated for treatment of heart failure three years in a row and ranked among the top ten in Tennessee for overall cardiac services two years in a row.

Mountain View Regional Medical Center. Mountain View Regional Medical Center was founded in the Norton, Virginia in 1948. The hospital joined the Wellmont System in 2007. The 118-bed facility (44 long term care beds) is staffed by 55 board-certified physicians and 240 employees. Medical and surgical services are provided with the support of an emergency room and diagnostic imaging including a 64-slice CT/cardiac imaging. Mountain View Regional Medical Center houses the System's only long term care unit.

Lee Regional Medical Center. Lee Regional Medical Center was founded in Pennington Gap, Virginia in 1930 and has served as the only county hospital for more than 70 years. The hospital joined the Wellmont System in 2007. The 70-bed facility is staffed by 34 board-certified physicians and 227 employees. Lee Regional Medical Center provides 24-hour emergency services, as well as a broad array of inpatient and outpatient medical and surgical services. The hospital also offers outpatient rehabilitation and cardiac stress testing.

Lonesome Pine Hospital. Lonesome Pine Hospital, located in Big Stone Gap, Va., is a 60-bed facility that has served the community since 1973. Lonesome Pine joined the Wellmont System in 1997. The facility is staffed by 104 board-certified physicians and 266 employees. Services include emergency care, intensive care, a medical/surgical/pediatric unit and obstetrics. The Southwest Virginia Cancer Center serving medical and radiation oncology patients is part of Lonesome Pine Hospital operations.

Hawkins County Memorial Hospital. On July 1, 2000, Hawkins County Memorial Hospital became the fourth member hospital in the Wellmont Health System. Established in 1961, the 50-bed, primary-care hospital provides care in a rural setting with a staff of 100 board-certified physicians and 203 employees. Services include emergency care, inpatient and outpatient surgery, occupational therapy, physical therapy and radiology. Outpatient clinics include gynecology, cardiology, gastroenterology, neurology, orthopedics, pulmonology, chemotherapy and urology.

Hancock County Hospital. Hancock County Hospital opened in April 2005. This innovative facility has been designated by the state as a critical-access hospital that provides care to a medically underserved region. The hospital was built through a partnership between the Wellmont System and the Hancock County Commission. Dedicated physicians and a staff of 53 employees provide inpatient and outpatient acute care, emergency care, radiology, laboratory services, respiratory therapy and physical therapy.

Takoma Regional Hospital. Takoma Regional Hospital was founded in 1928 in Greeneville, TN. The 100-bed acute care hospital is owned 60/40 and operated 50/50 through a management agreement with Adventist as a joint venture between Wellmont and Adventist Health System since 2007. The 369 employees provide emergency services, obstetric services, surgery, imaging and diagnostic services to the community.

Physician Clinics

Through its integrated physicians, Wellmont offers a network of primary care and specialty clinics located throughout the service area. The Wellmont Clinic is a physician led, professionally managed organization of 113 physicians and over 590 employees that provide nationally recognized cardiovascular care, medical oncology services, pulmonary and sleep services, surgical services, obstetric and gynecological services, family and internal medicine and hospitalists' services through our clinics and hospitals.

Historical Utilization

The following table sets forth selected historical utilization statistics of the inpatient and specialty care facilities owned and operated by Wellmont for fiscal years ended June 30, 2008, 2009 and 2010 and the six months ended December 31, 2009 and 2010.

Utilization Statistics

	Fiscal Year Ended June 30,			Six months Ended December 31,	
	2008	**2009**	**2010**	**2009**	**2010**
Hospital Statistics:					
Beds In Service	781	781	781	781	781
Discharges	42,401	42,558	41,380	20,468	20,934
Observations	5,973	8,092	9,530	4,633	4,722
Patients in Bed	48,374	50,650	50,910	25,101	25,656
Patient Days	181,400	183,913	177,715	87,962	90,497
Average Length of Stay (Days)	4.28	4.32	4.29	4.30	4.32
Daily Census[(1)]	513	526	513	503	517
Percent Occupancy	65.73%	67.35%	65.69%	64.40%	66.20%
Emergency Room Visits	227,181	222,560	212,383	108,847	101,851
Outpatient Registrations excluding ER	N/A	221,942	218,400	110,346	110,880
Deliveries	2,235	2,229	2,238	1,149	1,112
Surgical Cases:					
Inpatient	10,403	10,684	10,372	5,234	5,040
Outpatient	27,018	28,206	26,187	12,716	13,554
Physician Office Visits:	236,555	242,251	258,263	124,735	149,444

[(1)]Daily Census is Patient Days divided by 365 plus observations

Source: Wellmont management

PROGRAMS AND SERVICES

Specialty Services

Wellmont hospitals offer an array of medical specialties and sub-specialties that remain on the forefront of medical innovation through the partnership and drive of our experienced physicians and caregivers, some of the finest in the Southeast. Each of our medical specialties is complemented by a team of caring professionals dedicated to providing our patients and their families the best possible care.

At Wellmont, we believe there is no substitute for expertise. And we also believe each patient deserves to be cared for in an environment of comfort and healing. We deliver superior care with compassion.

Wellmont CVA Heart Institute. The Wellmont CVA Heart Institute provides a comprehensive cardiovascular program, including preventative, diagnostic, and interventional services on a regionally integrated basis. Wellmont's heart program has been repeatedly recognized for quality outcomes by some

of the nation's leading ratings groups and organizations. These awards serve as independent measures of our commitment to quality and provision of the best possible heart care.

The best heart care involves an integrated approach, bringing leading cardiovascular physicians together with cutting-edge cardiovascular technologies and treatments. The Wellmont CVA Heart Institute brings together seamless integration of top-quality heart services on a level never before realized in Northeast Tennessee and Southwest Virginia through the region's only Level One Heart Attack Network.

The Wellmont CVA Heart Institute is:

- 36 leading cardiologists and cardiac surgeons
- Eight member hospitals of Wellmont Health System
- Nine community cardiac offices with locations across Northeast Tennessee and Southwest Virginia

Wellmont Cancer Institute. The Wellmont Cancer Institute provides comprehensive cancer care, including cyberknife robotic radiosurgery, gliasite, image-guided and intensity-modulated radiation therapy, chemotherapy, counseling services, nutritional services, and patient education. More than 20 oncologists and surgeons practice at the Wellmont Cancer Institute. In addition, the Wellmont Cancer Institute performs research on the prevention and treatment of cancer. The Wellmont Cancer Institute locations include:

- The Christine LaGuardia Phillips Cancer Center at Holston Valley Medical Center
- The J.D. and Lorraine Nicewonder Cancer Center at Bristol Regional Medical Center
- Kingsport Hematology Oncology on Holston Valley Medical Center's outpatient campus
- Tri-City Oncology Center on Bristol Regional Medical Center's campus
- Blue Ridge Medical Specialists on the Bristol Regional Medical Center campus
- The Southwest Virginia Cancer Center, Norton, Va.
- Abingdon Hematology Oncology, Abingdon, Va

Wellmont Stroke Center. As the first certified primary stroke center in the region, the Primary Stroke Center at Bristol Regional Medical Center leads the way in exceptional stroke care. Bristol Regional is a founding member of the Appalachian Regional Stroke Center Network (ARSCN).

The Primary Stroke Center at Bristol Regional has full neurological coverage 24 hours a day, seven days a week. The professionals at the stroke center also provide their expertise to the member hospitals of the ARSCN when a patient presents with stroke. Along with Bristol Regional, Lonesome Pine Hospital is a founding member of the ARSCN. Holston Valley Medical Center also provides specialized stroke care.

Wellmont Emergency Services. Wellmont provides emergency services at all eight hospitals with one of the State's six Level I Trauma Centers located at Holston Valley Medical Center and affiliated with East Tennessee State University and its traumatologists. Bristol Regional Hospital offers Level II Trauma Center services. Our Holston Valley and Bristol Regional trauma programs are supported by WellmontOne Air Transport and by MedFlight (a partnership with the Virginia State Police). The emergency departments at all Wellmont Hospitals are staffed with exceptionally trained and highly experienced staff members and physicians to ensure the best care possible. Patient care liaisons and pastoral care staff are available to provide additional resources, spiritual counseling and emotional support.

Other Services

Marsh Regional Blood Center. Since its establishment as the region's first independent blood bank at Holston Valley Community Hospital in 1947, the goal of Marsh Regional Blood Center has been to collect and maintain a local blood supply to meet local needs. Through generous support from donors, it has grown steadily. In 1987, it was officially named Marsh Regional in honor of Lois Marsh, its founder and supervisor for forty years.

Today, Marsh Regional continues to operate as an independent blood center, providing a safe and affordable blood supply to hospitals and other medical facilities throughout Northeast Tennessee and Southwest Virginia. Each year Marsh Regional collects, processes, tests, stores and distributes tens of thousands of units of blood and blood products.

Marsh Regional Blood Center is a member of **American Association of Blood Banks** and the **Tennessee Association of Blood Banks** and is a federally inspected and licensed blood center through the **Food & Drug Administration**.

Wellmont Nurse Connection. Wellmont Nurse Connection provides health information any time, 24 hours a day, seven days a week. Experienced nurses are available to answer questions via a toll free Wellmont Nurse Connection phone line. An online library may be accessed by patients to learn more about a variety of essential health topics.

Wellmont's Healing Environment. Wellmont's Healing Environment utilizes Shepherds, specially trained and empowered caregivers who exhibit a passion for helping patients heal – physically, mentally and spiritually. These Shepherds are dedicated to creating healing spaces around us, healing attitudes within us and healing relationships between us.

The Healing Environment focuses as much energy on healing patients as it does on curing diseases. In a Healing Environment, patients are the focal points. Decisions are made and actions are taken with our patients first and foremost in mind.

The Healing Environment is not a new concept. Its principles are rooted in the basic concepts of medicine and in the idea that we are each capable of being a Good Samaritan. At times, that may involve the simple offering of a kind word or a compassionate heart. And the Healing Environment acknowledges that sometimes, when that is all we have to give, it is also what is most needed.

The Healing Environment is more than a program or a set of guidelines for care. It is a concept that takes care to another level and a set of principles that promotes true healing.

Other Activities

Graduate Medical Education. Wellmont operates seven accredited residency training programs through affiliations with East Tennessee State University and Lincoln Memorial University: two in Family Medicine, two in Internal Medicine, two in General Surgery and one osteopathic family medicine program. Eighty-three full-time residents participate in the seven programs. Wellmont will be adding a new osteopathic orthopedic residency program affiliated with Lincoln Memorial University in July 2011 with 6 additional residents.

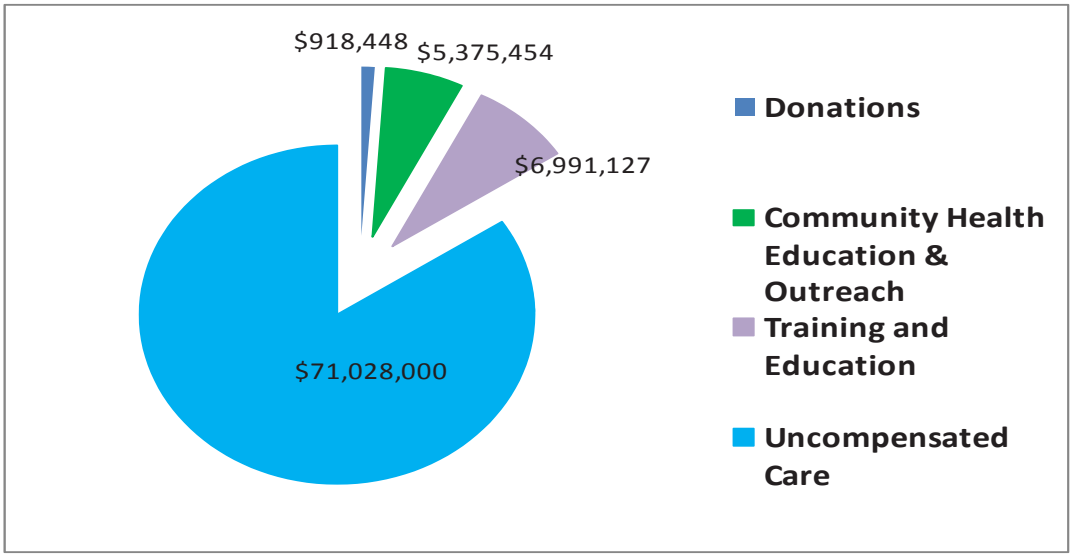
Other Education Programs. Wellmont participates in other education programs for a variety of patient care professions. The 156 programs with 79 different institutions include registered nurse,

certified nursing assistant, physical therapist, surgical technician and respiratory therapist training programs.

Community Health Education. Wellmont offers a variety of courses for the community, as well as for patients and families. Through free health fairs, screenings, lectures and events, we devote significant financial and human resources to help area residents become more aware of their health and wellness. Wellmont serves as the regional affiliate for Children's Miracle Network Hospitals and the American Heart Association's Go Red for Women initiative and supports Susan G. Komen for the Cure.

CHARITY CARE

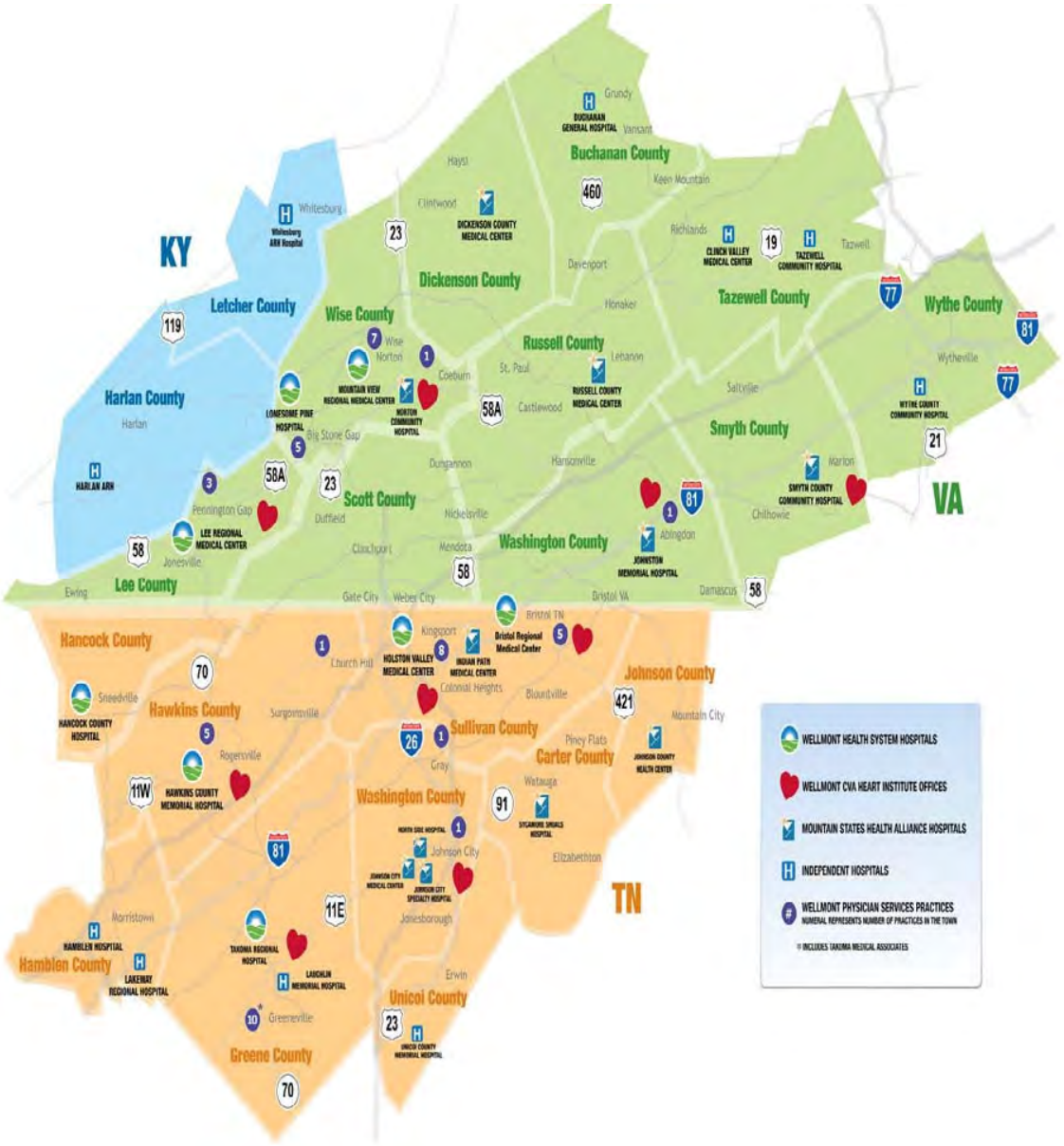
Wellmont offers free or discounted hospital services for those who cannot afford to pay. At Wellmont, a patient with an annual income of less than 200% of the federal poverty level will qualify for a full uncompensated care write-off. In 2010, the cost to Wellmont of providing uncompensated care was $71 million. Wellmont provides financial assistance for uninsured patients in cases when the annual family income is over 200% of the federal poverty level and the account balance is equal to or greater than 100% of the patients total annual household income. Wellmont has adopted a charity care policy that is designed to ensure that financial constraints are not a barrier to the provision of care.



SERVICE AREA AND COMPETITION

Composition of Service Area

Wellmont's service area is defined by management at the county level based on patient activity and locations of our campuses. The primary service area ("PSA") includes the Tennessee counties of Sullivan, Hawkins and Hancock and the Virginia counties of Washington, Wise, Lee and Scott. The Virginia secondary service area ("VSSA") is defined as Russell, Buchanan, Smyth, Tazewell, Dickenson and Wythe counties. The Tennessee secondary service area ("TSSA") is defined as Washington, Greene, Carter, Johnson and Unicoi counties. The map below details the service area:



Demographic Information

Below is certain demographic information for Wellmont's Service Area:

WHS Market Population, Growth and Household Income

	2010 Total Pop	2015 Total Pop	2010-2015 Growth	2010 Median HH Income
Primary Service Area				
Sullivan, TN	158,441	159,123	0.4%	$40,490
Washington, VA	69,294	70,053	1.1%	$40,298
Wise, VA	49,083	48,461	-1.3%	$33,715
Hawkins, TN	55,420	57,285	3.4%	$34,630
Lee, VA	22,479	22,711	1.0%	$30,703
Scott, VA	23,894	23,834	-0.3%	$34,695
Hancock, TN	6,074	6,008	-1.1%	$39,794
	384,685	**387,475**	**0.7%**	**$37,711**
Secondary Service Area				
Russell, VA	29,223	28,847	-1.3%	$34,564
Washington, TN	133,110	140,203	5.3%	$41,280
Buchanan, VA	24,667	23,000	-6.8%	$28,037
Smyth, VA	32,010	31,185	-2.6%	$36,892
Tazewell, VA	42,107	41,470	-1.5%	$36,754
Dickenson, VA	14,730	14,617	-0.8%	$29,698
Greene, TN	64,833	66,282	2.2%	$35,725
Carter, TN	46,870	47,657	1.7%	$32,003
Wythe, VA	31,116	31,418	1.0%	$40,043
Johnson, TN	19,620	19,902	1.4%	$28,627
Unicoi, TN	17,894	17,895	0.0%	$36,135
	456,180	**462,476**	**1.4%**	**$33,982**

Source: MedStat

Percentage Rate of Unemployment

	2008	2009	2010
Primary Service Area			
Sullivan, TN	5.4%	8.9%	9.3%
Washington, VA	4.9%	8.5%	9.1%
Wise, VA	4.6%	7.0%	7.5%
Hawkins, TN	6.8%	11.4%	10.3%
Lee, VA	5.3%	7.1%	7.5%
Scott, VA	5.4%	9.5%	10.4%
Hancock, TN	8.4%	15.2%	16.4%
Secondary Service Area			
Russell, VA	5.7%	10.8%	9.6%
Washington, TN	5.7%	8.8%	9.1%
Buchanan, VA	5.0%	9.0%	8.7%
Smyth, VA	6.1%	11.4%	10.8%
Tazewell, VA	4.4%	7.6%	6.7%
Dickenson, VA	5.7%	9.0%	8.4%
Greene, TN	9.5%	15.9%	15.2%
Carter, TN	6.7%	10.3%	10.6%
Wythe, VA	5.3%	10.6%	10.2%
Johnson, TN	5.1%	12.6%	13.8%
Unicoi, TN	7.5%	11.6%	12.2%
Tennessee	6.7%	10.5%	9.7%
Virginia	3.9%	6.7%	6.9%
United States	5.8%	9.3%	9.7%

Source: U.S. Bureau of Labor Statistics

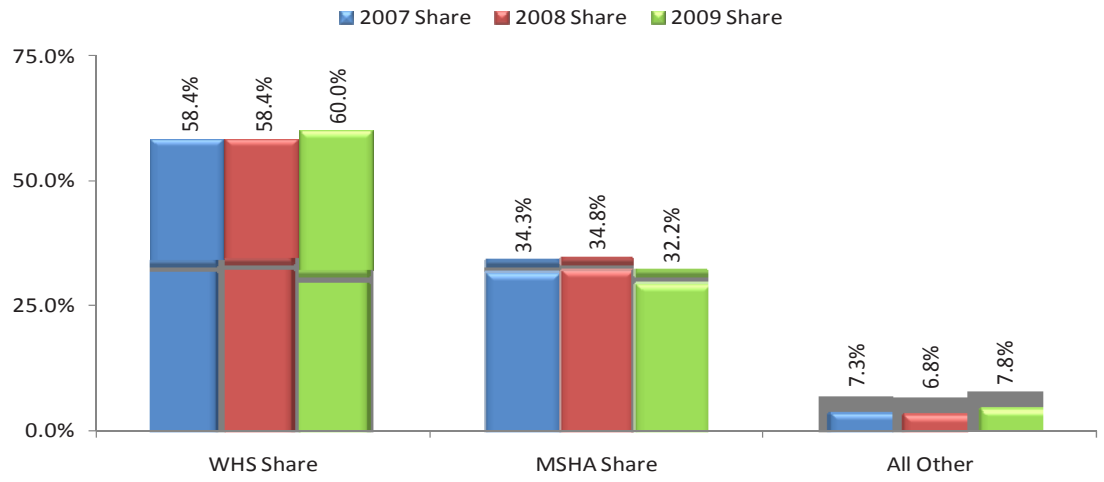
Patient Origin by Service Area

The following tables show patient volume based on service area for Wellmont during fiscal years 2009 and 2010.

	WHS Inpatient Origin				WHS Outpatient Origin			
	FY 2009	FY 2010	FY 10 % to Total	FY 09 - FY 10 Growth	FY 2009	FY 2010	FY 10 % to Total	FY 09 - FY 10 Growth
Primary Service Area								
Sullivan, TN	14,151	13,885	31.1%	-1.9%	134,629	132,098	34.0%	-1.9%
Washington, VA	5,526	5,626	12.6%	1.8%	44,036	43,122	11.1%	-2.1%
Wise, VA	5,505	5,186	11.6%	-5.8%	56,738	60,429	15.6%	6.5%
Hawkins, TN	4,860	4,795	10.7%	-1.3%	47,731	46,214	11.9%	-3.2%
Lee, VA	3,809	3,651	8.2%	-4.2%	41,653	40,725	10.5%	-2.2%
Scott, VA	2,641	2,640	5.9%	0.0%	17,427	17,440	4.5%	0.1%
Hancock, TN	849	859	1.9%	1.2%	6,472	6,223	1.6%	-3.9%
PSA Total	**37,341**	**36,642**	**81.9%**	**-1.9%**	**348,686**	**346,251**	89.1%	**-0.7%**
Secondary Service Area								
Russell, VA	1,149	1,124	2.5%	-2.2%	6,187	6,408	1.7%	3.6%
Washington, TN	1,036	1,050	2.4%	1.4%	8,637	8,318	2.1%	-3.7%
Buchanan, VA	835	777	1.7%	-7.0%	2,247	2,452	0.6%	9.1%
Smyth, VA	782	717	1.6%	-8.3%	3,548	3,286	0.9%	-7.4%
Tazewell, VA	752	876	2.0%	16.5%	2,197	2,481	0.6%	12.9%
Dickenson, VA	717	742	1.7%	3.5%	4,895	4,952	1.3%	1.2%
Greene, TN	466	516	1.2%	10.7%	1,982	2,062	0.5%	4.0%
Carter, TN	173	184	0.4%	6.4%	1,276	1,189	0.3%	-6.8%
Wythe, VA	164	148	0.3%	-9.8%	414	432	0.1%	4.4%
Johnson, TN	108	133	0.3%	23.2%	693	648	0.2%	-6.5%
Unicoi, TN	44	27	0.1%	-38.6%	288	223	0.1%	-22.6%
SSA Total	**6,226**	**6,294**	**14.1%**	**1.1%**	**32,364**	**32,451**	8.4%	**0.3%**
All Other	1,874	1,785	4.0%	-4.8%	11,025	9,984	2.6%	-9.4%
GRAND TOTAL	**45,441**	**44,721**	**100.0%**	**-1.6%**	**392,075**	**388,686**	100.0%	**-0.9%**

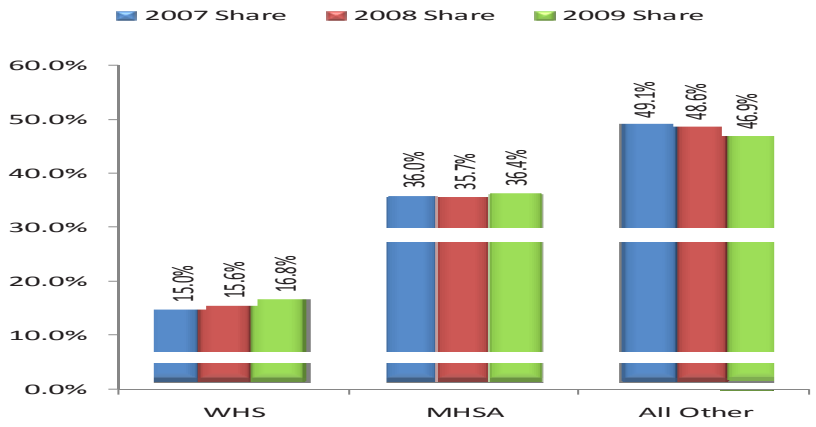
Source: Wellmont Patient Encounter Records

2007-2009 Inpatient Market Share – PSA

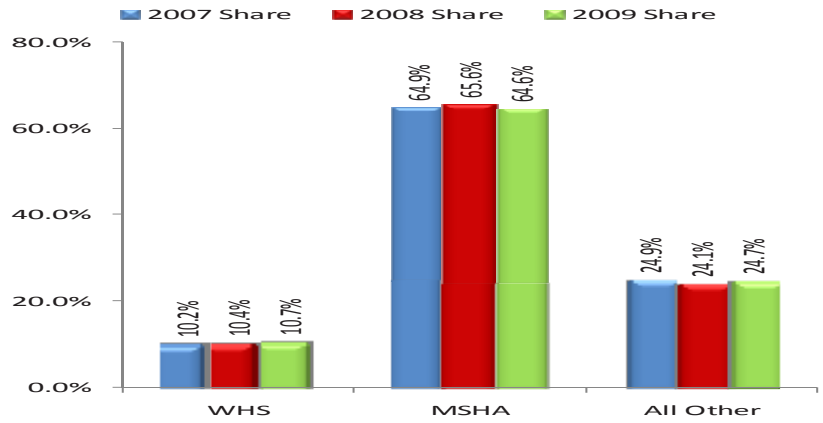


WHS – Wellmont Health System; MSHA – Mountain States Health Alliance

2007-2009 Inpatient Market Share – VSSA



2007-2009 Inpatient Market Share – TSSA



HISTORICAL FINANCIAL INFORMATION

General

The following consolidated financial results of operations and changes in net assets and consolidated balance sheets of Wellmont and its affiliates (all of which are listed in the organizational chart on page A-2 hereof and collectively hereinafter referred to as "Wellmont and Affiliates") as of and for the years ended June 30, 2008, June 30, 2009 and June 30, 2010 are derived from consolidated financial statements which have been audited by KPMG, LLP, independent auditors. The financial information below and in audited financial statements of Wellmont and Affiliates, included in Appendix B hereto, includes affiliates of Wellmont that are not Members of the Obligated Group. Affiliates of Wellmont which are not Members of the Obligated Group contributed less than 1.5% of the total revenues for the fiscal years ended June 30, 2008, 2009 and 2010 and less than 1.5% of the total revenues for the six-months ended December 31, 2009 and 2010. The data should be read in conjunction with the

consolidated audited financial statements, related notes and other financial information contained herein as Appendix B.

Summary Financial Information

The following consolidated statement of operations and changes in net assets and balance sheets of Wellmont and Affiliates for the three fiscal years ended June 30, 2008, 2009 and 2010 have been derived from the audited consolidated financial statements of Wellmont and Affiliates. The complete audited consolidated financial statements and supplemental information for the fiscal years ended June 30, 2009 and 2010 are included in APPENDIX B – "WELLMONT HEALTH SYSTEM AND AFFILIATES CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTAL INFORMATION" hereto. The following summary consolidated financial information should be read in conjunction with the section herein entitled "MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL INFORMATION" and the complete audited consolidated financial statements and related notes that appear in APPENDIX B.

The following consolidated statement of operations and changes in net assets and balance sheets of Wellmont and Affiliates for the six months ended December 31, 2009 and 2010 were derived from the internal unaudited financial statements for such periods. The financial data for the six months ended December 31, 2009 and 2010 include all adjustments management of Wellmont considers necessary to present such information in conformity with accounting principles generally accepted in the United States of America on a basis consistent with that of the audited financial statements for the fiscal year ended June 30, 2010. The results of operations and changes in net assets for the six months ended December 31, 2010 are not necessarily indicative of the operating results to be expected for the entire fiscal year ending June 30, 2011.

Wellmont Health System and Affiliates
Combined Statements of Operations and Changes in Net Assets
(Dollars in Thousands)

	Fiscal Years ended June 30,			*6 months ended December 31,*	
	2008	**2009**	**2010**	***2009***	**2010**
				Unaudited	***Unaudited***
Revenue:					
Net patient revenue	$679,874	$680,056	$692,920	$342,363	$375,374
Other revenue	27,211	27,842	31,472	15,968	14,488
Total revenue	707,085	707,898	724,392	358,331	389,862
Expenses:					
Salaries and benefits	314,034	323,801	310,667	152,813	170,104
Medical supplies and drugs	134,304	141,044	150,143	74,499	80,131
Purchased services	81,824	81,031	74,922	36,342	39,455
Interest	14,279	16,013	20,110	8,933	10,819
Provision for bad debts	57,794	33,402	35,293	17,888	18,258
Depreciation and amortization	39,421	42,957	43,711	20,981	23,201
Other	63,038	62,604	66,734	31,445	43,514
Total expenses	704,694	700,852	701,580	342,901	385,482
Income from operations	$2,391	$7,046	$22,812	$15,430	$4,380
Nonoperating gains (losses)(1):					
Investment income	31,580	4,181	1,012	5,153	6,960
Derivative valuation adjustments	(4,539)	(5,747)	(2,693)	2,584	1,685
Other, net	(42)	293	(805)	-	(611)
Nonoperating (losses) gains, net	26,999	(1,273)	(2,486)	7,737	8,034
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	$29,390	$5,773	$20,326	$23,167	$12,414
Discontinued operations	(6,976)	(4,455)	(1,109)	(878)	86
Revenues and gains in excess of expenses and losses	$22,414	$1,318	$19,217	$22,289	$12,500
Income attributable to noncontrolling interests	(177)	(918)	(1,065)	(531)	(779)
Revenues and gains in excess of expenses and losses attributable to WHS	$22,237	$400	$18,152	$21,758	$11,721
Other changes in unrestricted net assets (1):					
Change in net unrealized gains (losses) on investments	(40,398)	(60,663)	22,312	26,400	31,982
Net assets released from restrictions for additions to land, buildings and equipment	2,124	2,758	1,555	386	1,156
Transfer to/from permanently restricted net assets	-	-	-	79	-
Change in the funded status of benefit plans and other	(1,536)	(13,568)	(3,429)	(843)	14
Increase (decrease) in unrestricted net assets	(17,573)	(71,073)	38,590	47,780	44,873
Changes in temporarily restricted net assets:					
Contributions	3,539	1,944	2,934	1,132	1,280
Net assets released from temporary restrictions	(2,124)	(3,154)	(1,972)	(482)	(1,372)
Increase (decrease) in temporarily restricted net assets	1,415	(1,210)	962	650	(92)
Changes in permanently restricted net assets:					
Transfer to/from unrestricted net assets	-	-	-	(79)	-
Permanently restricted contributions and investment income	10	645	(77)	1	2
Increase (decrease) in permanently restricted net assets	10	645	(77)	(78)	2
Changes in noncontrolling interests (1):					
Adjustment to noncontrolling interest from the adoption of authoritative guidance	1,142	-	-	-	-
Income attributable to non-contolling interests	177	918	1,065	531	871
Distributions to noncontrolling interests	-	(426)	(711)	(537)	(671)
Changes in noncontrolling percentages	-	243	(21)	-	(92)
Increase (decrease) in noncontrolling interests	1,319	735	333	(6)	108
Change in net assets (1)	(14,829)	(70,903)	39,808	48,346	44,891
Net assets, beginning of period (1)	412,650	397,821	326,918	326,918	366,726
Net assets, end of period (1)	$397,821	$326,918	$366,726	$375,264	$411,617

(1) Reflects change from "minority interests" to "noncontrolling interests" from the adoption of authoritative guidance and reflects Medical Mall Pharmacy as discontinued operations for all periods.

Wellmont Health System and Affiliates
Consolidated Balance Sheets
(Dollars in Thousands)

	June 30,			December 31,	
	2008	**2009**	**2010**	***2009*** **Unaudited**	**2010 Unaudited**
Current assets:					
Cash and cash equivalents	$ 13,787	$ 60,889	$ 35,711	$ 55,608	$ 50,068
Assets limited as to use	2,235	2,201	1,815	-	-
Patient accounts receivable	109,514	98,071	94,057	90,510	104,374
Other receivables	12,714	11,173	10,919	10,994	9,953
Inventories	16,816	17,169	18,294	17,911	18,050
Prepaid expenses & other current assets	6,008	6,040	7,003	6,840	9,017
Total current assets	161,074	195,543	167,799	181,863	191,462
AWUIL, net of current portion	346,414	245,600	301,807	268,298	297,211
Land, buildings and equipment, net	406,214	442,610	450,205	449,736	446,569
Other assets:					
Long-term investments	35,571	31,974	32,391	34,707	35,324
Investments in affiliates	29,155	31,976	32,019	32,180	31,084
Deferred debt expense, net	5,062	4,824	4,644	4,728	4,709
Goodwill, net	9,641	9,509	9,501	9,496	16,628
Other	7,059	798	730	713	2,304
	86,488	79,081	79,285	81,824	90,049
Total assets	$ 1,000,190	$ 962,834	$ 999,096	$ 981,721	$ 1,025,291
Current liabilities:					
Current portion of long-term debt	$ 10,237	$ 13,197	$ 11,958	$ 11,846	$ 9,858
Line of credit/Short-term notes	17,932	15,811	14,000	14,000	14,000
Accounts payable and accrued expenses	76,958	77,139	74,679	62,536	67,316
Estimated third-party payor settlements	2,086	12,441	11,672	9,300	13,820
Current portion of other LT liabilities	4,915	6,352	7,251	6,802	8,380
Total current liabilities	112,128	124,940	119,560	104,484	113,374
Long-term debt, less current portion	469,321	474,608	467,833	466,841	456,086
Other long-term liabilities, less current(1)	20,920	36,368	44,977	35,132	44,214
Total liabilities	602,369	635,916	632,370	606,457	613,674
Net assets:					
Unrestricted	391,103	320,030	358,620	367,731	403,491
Temporarily restricted	4,799	3,589	4,551	4,239	4,460
Permanently restricted	600	1,245	1,168	1,246	1,170
Noncontrolling interests (1)	1,319	2,054	2,387	2,048	2,496
Total net assets	397,821	326,918	366,726	375,264	411,617
Total liabilities and net assets	$ 1,000,190	$ 962,834	$ 999,096	$ 981,721	$ 1,025,291

(1) Reflects change from "minority interests" to "noncontrolling interests" from the adoption of authoritative guidance.

Sources of Patient Service Revenue

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2008, 2009 and 2010, and the six months ended December 31, 2010.

Sources of Revenue

	June 30,			December 31,
	2008	2009	2010	2010
Medicare	34.5%	33.6%	32.5%	32.7%
Medicaid	13.5%	13.5%	13.5%	12.9%
Self Pay	6.1%	6.2%	6.5%	6.7%
Medicare Managed Care	14.7%	17.0%	18.4%	18.8%
Managed Care	25.8%	25.1%	25.0%	25.3%
Other	5.4%	4.7%	4.2%	3.5%
	100.0%	100.0%	100.0%	100.0%

Source: Wellmont management

Approximately 49 percent of Wellmont's revenue sources are under managed care contracts – 6% in TennCare, 19% in Medicare Managed Care and 25% in Managed Care. The Medicare and TennCare contracts cover 127,000 lives in our service area. Wellmont Health System has contracts with 29 different managed care companies. Approximately 87 percent of our managed care revenues are concentrated with four different payors. Our contracts are normally reimbursed on a case basis with a percent of charge applied to most outpatient business.

Capitalization

The following table sets forth the capitalization ratios for Wellmont and Affiliates as of June 30, 2008, 2009 and 2010 and as of December 31, 2010.

		June 30			December 31
		2008	2009	2010	2010
		(dollars in thousands)			
Capitalization					
Current portion of long-term debt		$ 10,237	$ 13,197	$ 11,958	$ 9,858
Lines of credit/short-term notes payable		17,932	15,811	14,000	14,000
Long-term debt, less current portion	A	469,321	474,608	467,833	456,086
Total debt		497,490	503,616	493,791	479,944
Unrestricted net assets	B	391,103	320,030	358,620	403,491
Other net assets		6,718	6,888	8,106	8,126
Total net assets		397,821	326,918	366,726	411,617
Long-term debt plus Unrestricted net assets	A+B	$ 860,424	$ 794,638	$ 826,453	$ 859,577
Long-term debt to Capitalization	A/(A+B)	0.545	0.597	0.566	0.531

Estimated Days Cash on Hand

The following table sets forth, for Wellmont and Affiliates, on a consolidated basis, the annual days cash on hand ratios for the fiscal years ended June 30, 2008, 2009 and 2010, and twelve months ended December 31, 2010.

	June 30			December 31
	2008	2009	2010	2010
	(dollars in thousands)			
Days Cash on Hand				
Unrestricted cash	$ 13,787	$ 60,889	$ 35,711	$ 50,068
Unrestricted investments:				
Capital improvements	200,469	157,467	247,674	244,120
Long-term investments	35,571	31,974	32,391	35,324
Less illiquid investments	(40,803)	(34,682)	(35,003)	(36,253)
	209,024	215,648	280,773	293,259
Operating expenses (12 months)	704,694	700,852	701,580	744,161
Less depreciation and amortization	(39,421)	(42,957)	(43,711)	(45,931)
Total cash expenses	665,273	657,895	657,869	698,230
Number of days in the period	366	365	365	365
Daily cash operating expenses	$ 1,818	$ 1,802	$ 1,802	$ 1,913
Days cash on hand	114.99	119.64	155.78	153.30

Historical Annual Debt Service Coverage

The following table sets forth, for Wellmont and Affiliates, on a consolidated basis, the actual historical annual debt service coverage ratio calculated in accordance with the Master Indenture for the fiscal years ended June 30, 2008, 2009 and 2010, and twelve months ended December 31, 2010.

		June 30			December 31
		2008	2009	2010	2010
		(dollars in thousands)			
Debt Service Coverage					
Revenue and gains in excess of expenses and losses (12 months)		$ 22,414	$ 1,318	$ 19,217	$ 9,428
Add back:					
Depreciation and amortization (12 months)		39,421	42,957	43,711	45,931
Interest expense (12 months)		14,279	16,013	20,110	21,996
Loss from discontinued operations (12 months)		6,976	4,455	1,109	145
Total income available for debt service per Master Trust Indenture	C	83,090	64,743	84,147	77,500
Maximum annual debt service	D	$ 38,050	$ 38,050	$ 38,050	$ 37,810
Debt Service Coverage Ratio per Master Trust Indenture	C/D	2.18	1.70	2.21	2.05

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL INFORMATION

Accounting Policies and Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the

consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates include: the carrying amounts for goodwill, and property, plant, and equipment; valuation allowances for receivables; and liabilities for claims incurred but not reported under self-insured programs. Actual results could differ from those estimates.

For more information regarding Wellmont's accounting policies, see the notes to the audited consolidated financial statements that appear in APPENDIX B.

Historical Performance

Fiscal Year Ended June 30, 2009 vs. 2008

Net patient collections (defined as net patient revenues less bad debt) increased by $24.6 million or 4.0 percent for the fiscal year ended June 30, 2009 compared to the same period in 2008. Patients in a bed, excluding newborns, were 50,650, which represented an increase of 2,276 (4.7 percent). Gross revenues increased by $69.0 million resulting from utilization increases as additional operations came on line. Contractual adjustments and bad debt were higher by $40.0 million, reflective of modest payor mix changes. Charity care increased by $4.5 million versus 2008, reflective of the overall utilization increases. The increase is net of the effect of reclassification of certain accounts as charity care versus bad debt due to a policy change.

Salaries, benefits and purchased services increased by $9.0 million or 2.3 percent. Rate of pay and benefits increases provided to employees caused the increase. Supply costs increased by $6.7 million or 5.0 percent as a result of volume along with increases in price and mix of services provided. Other direct expenses decreased slightly ($0.4 million or 0.7 percent) over the same period last year. This was caused by increases in lease, rental, repair and maintenance offset by consulting and discretionary spending control.

Bad debt expense reflects a significant decrease due to a change in policy resulting in a reclassification of accounts as charity versus bad debt in FY 2009. The slight net increase associated with volume and shift to Medicare Managed Care is reflected in the net collections discussed above.

Interest, depreciation and amortization increased by $5.3 million or 9.8 percent related to purchases and Project Platinum coming on line.

Operating income was a $7.1 million or a 1.0 percent margin compared to $2.4 million or a .30 percent margin for fiscal year 2008.

Investment income was lower in fiscal year 2009 than in fiscal year 2008 given greater investment market volatility. Discontinued operations included the impact of Jenkins Community Hospital and Medical Mall Pharmacy over the two periods.

Excess of Revenues over Expenses was $1.3 million in fiscal year 2009 compared to $22.4 million for fiscal year 2008.

Fiscal Year Ended June 30, 2010 vs. 2009

Net patient collections increased by $11.0 million or 1.7 percent for the fiscal year ended June 30, 2010 compared to the same period in 2009. Patients in a bed, excluding newborns, were 50,910, which represented an increase of 260 (.5 percent). Gross revenues decreased by $19.2 million resulting from overall volume and utilization decreases. Contractual adjustments and bad debt were lower by $27.1

million, reflective of utilization changes and improvements in reimbursement and contracted rates. Charity care decreased by $2.9 million versus 2009, reflective of the utilization changes combined with slight payor mix changes.

Salaries, benefits and purchased services expenses decreased year over year by $19.2 million or 4.8 percent. This decrease was driven by a reduction of full time equivalents and contractual obligation negotiations to reduce costs and right size operations. Supply expense was higher year over year by $9.1 million or 6.5 percent. $4 million of the supply increase is directly related to the increase in blood products. Drug costs drove another $3.8 million of the increase primarily related to oncology drug costs. Other operating expense increased by $4.1 million or 6.6 percent as a result of fees and other changes in expense structure associated with the right-sizing.

Bad debt expense increased by $1.9 million or 5.7 percent because employers and payors shifted a larger amount of expenses to co-payments and deductibles.

Interest, depreciation and amortization increased by $4.8 million or 8.2 percent related to Project Platinum coming on line and additional debt-related expenses.

Operating income was $22.8 million or a 3.2 percent margin in fiscal year 2010, compared to $7.1 million or a 1.0 percent margin in fiscal year 2009.

Investment income was lower in FY 2010 as a result of continued volatility in the market and the recognition of other than temporary losses. Discontinued operations were driven by the recognition of the sale of the Medical Mall Pharmacy operation.

Excess of Revenues over Expenses was $19.2 million compared to $1.3 million in the prior fiscal year.

Interim Six-Months Ended December 31, 2010 vs. 2009

Net patient revenue has grown 2.0% or $6.9 million over the previous six month period last year. This excludes the additional revenue of $16.6 million reported as a result of the merger of the cardiology practice in May 2010 and $9.5 million related to the TennCare fee assessment. The $9.5 million of fee assessment is offset in other expenses. Other revenue shows a decrease as a result of poor performance related to the Takoma joint venture.

Salaries and benefits for the six month period has increased over last year-to-date by $1.9 million or 1.2% , net of cardiology practice expenses of $15.4 million, driven by the increase in FTEs for patient care as well as to support computerized order entry and electronic health record system build and implementation. Supplies have increased by $4.6 million or 6.1%, net of cardiology practice expenses of $1.1 million, driven by higher drug costs, particularly in oncology, and utilization as well as volume.

Other expenses increased in the period over the same period last year by $0.7 million as a result of increases in rental to support new operations and increases in maintenance for software systems.

Interest and depreciation increases are related to the completion of Project Platinum

Year-to-date, growth in expenses has out-stripped the growth in revenues resulting in a 1.1% operating margin.

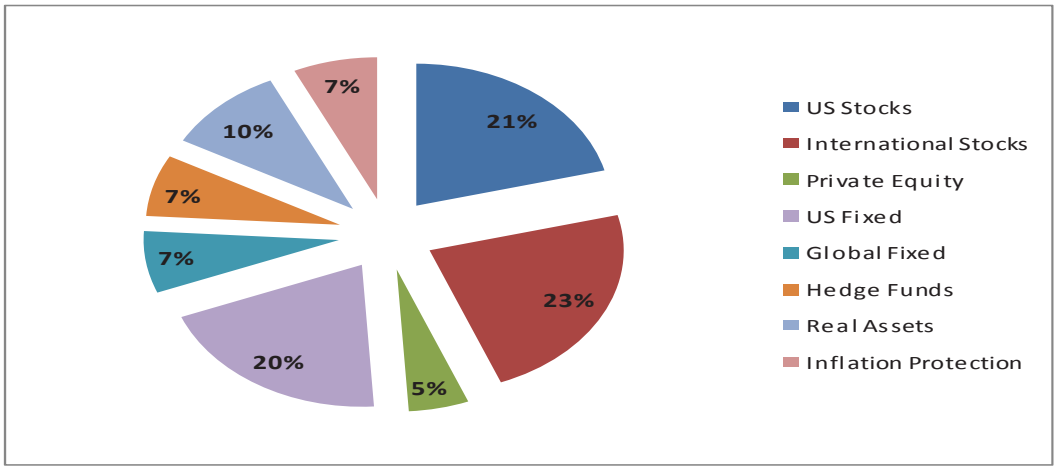
Investments are performing well with the rebound in the market while the mark-to-market on our derivatives is not as volatile as last year.

Discontinued operations include changes related to the valuation of the Jenkins' accounts receivable where last year also includes the Medical Mall Pharmacy operations.

Excess of Revenues over Expenses was $12.5 million compared to $22.3 million in the prior fiscal year.

Liquidity and Investment Policy

At December 31, 2010, Wellmont Health System had approximately $293.3 million of unrestricted cash and cash equivalents and investments. The following chart sets forth the asset allocation of those funds.



Board-designated investments are invested pursuant to an investment policy approved by the Board (the "Investment Policy"). The policy specifies allowable investments, liquidity needs, performance benchmarks and asset allocation guidelines. The Board has delegated the implementation of this policy to the Finance and Investment Committee, which consists of members of the Board and other appointed members.

At the beginning of 2010, Wellmont completed a revision to the Investment Policy and implemented an asset allocation study for the investment portfolio. Wellmont relied on an external investment consultant to conduct a study that reviewed the existing investment pool and associated allocations and the efficiency of the investment pool's performance to date. The investment advisor, at the direction of Wellmont management, considered the operating characteristics, including time horizon, liquidity requirements, return expectations and risk tolerance, as well as the overall objective for the investment pool for incorporation into its investment policy and asset allocations recommendation. The allocation targets for the investment pool were adopted as follows: 28% fixed income (risk reduction assets), 21% domestic equity, 21% international equity, 3% emerging market, 5% private equity/special purposes, 6% hedge funds and 16% in inflation protection assets. These target allocations are based upon a long-term outlook. Performance is monitored regularly and adjustments are made if necessary. Actual allocations may differ from target allocations in the short-term or during periods of significant market fluctuations, and there can be no assurance that Wellmont will always rebalance the investment portfolios.

The investment policies are subject to revision from time to time by the Finance and Investment Committee. There can be no assurance that Wellmont will achieve its investment objectives or that it will receive any return on their investments. Investment performance may be volatile, and Wellmont may lose a significant portion of its investment portfolio. Adverse economic and market conditions or other events could result in substantial or total loss in respect of some or all investments.

Achievement of investment income is subject to significant risks and Wellmont can give no assurance that its investments will generate any particular level of return. See "BONDHOLDERS' RISKS" in the forepart of this Official Statement. If Wellmont suffers investment losses, their business plans and financial results could be materially impacted.

Retirement Plan

Wellmont sponsors a retirement program and defined contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined contribution plans at Holston Valley and Bristol Regional. Wellmont makes annual contributions to the Retirement Plan in an amount equal to three percent of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Service Code, up to three percent of each participant's wages.

In addition, there is a legacy Wellmont Health System Defined Benefit Plan that includes grandfathered employees at Holston Valley and Lonesome Pine Hospitals. The Defined Benefit Plan is frozen and no further benefits accrue. The plan is actuarially valued annually and Wellmont recognizes the funded status as an asset or liability in its consolidated balance sheets and recognizes changes in funded status in the year in which the change occurs as a change in unrestricted net assets.

Certain Indebtedness and Liabilities

Wellmont's current and projected debt profiles (refinancing the 2006A Bonds with fixed rate debt with the same maturity to 2032 and replacing the letter of credit issued by Bank of America, N.A. securing the Series 2005 Bonds with a letter of credit issued by JP Morgan Chase Bank, N.A.) are shown in the schedules below:

Current Debt Profile:

Series	Par Outstanding	Structure	Credit Enhancement	Swaps	Maturity
2003	36,665,000	Fixed Rate	Radian		2019
2005	59,580,000	VRDBs	LOC (BAML)	Fixed Payer	2032
2006A	76,595,000	Index Floating Rate		TRS/Fixed Payer	2032
2006C	200,000,000	Fixed Rate			2036
2007A	55,000,000	Fixed Rate			2037
Capital Leases	19,270,174	Fixed Rate			Various
Notes Payable	5,944,842	Fixed Rate			Various
Line of Credit	14,000,000				2011
Series 2010 BQ	30,000,000	Index Floating Rate			2026
	497,055,016				

As of December 31, 2010

SWAP Profile:

Series	Notional	Related Bonds	Maturity	Receive	Pay	MTM
Basis Swap	62,730,000	Series 2002 (defeased)	2032	73.8% LIBOR	SIFMA	(2,267,701)
Total Return Swap	76,595,000	Series 2006A	2011	Bond Rate+1.10%	SIFMA	1,099,184
Fixed Payer	59,580,000	Series 2005	2016	67% 1M LIBOR	3.548%	(6,145,511)
Fixed Payer	35,342,000	Series 2006A	2021	67% 1M LIBOR	3.613%	(3,944,601)
TOTAL	234,247,000					(11,258,629)

As of December 31, 2010

Proposed Debt Profile:

Series	Par Outstanding	Structure	Credit Enhancement	Swaps	Maturity
2003	36,665,000	Fixed Rate	Radian		2019
2005	59,580,000	VRDBs	LOC (JPM)	Fixed Payer	2032
2011	76,165,000	Fixed Rate		Total Return Swap	2032
2006C	200,000,000	Fixed Rate			2036
2007A	55,000,000	Fixed Rate			2037
Capital Leases	19,270,174	Fixed Rate			Various
Notes Payable	5,944,842	Fixed Rate			Various
Line of Credit *	7,000,000				2011
Series 2010 BQ	30,000,000	Index Floating Rate			2026
	489,625,016				

After Issuance
* Paid $7M in January 2011

Capital Improvement Plans

Overview of 2011 Capital Budget. The 2011 capital budget is approximately $44.0 million. Management expects that $10.0 million will be spent on strategic items with the majority being spent on the purchase of the Southwest Virginia Cancer Center building and land. Before any individual project is commenced or significant capital costs are incurred, the project is evaluated by management to determine financial feasibility and is submitted for approval to the Board. Management expects that the sources of funding for the capital projects approved will be cash from operations and philanthropic donations. Management closely monitors the progress of each project, including oversight of the schedule and the budget, and regularly reports such progress to the Board.

CORPORATE GOVERNANCE

Wellmont Board of Directors

Wellmont is governed by the Board, which is composed of community members. The role of the Board is to establish policy, promote performance improvement and provide for necessary resources and organizational management and planning.

Each trustee is elected for a four-year term and may serve a maximum of two terms, which then must be followed by one year off the Board before being elected to serve again. The bylaws of Wellmont require that there be at least 13 and not more than 15 voting trustees, four of whom must be physicians. There are seven at large members, one member as designated by the Lonesome Pine Advisory Board, one member designated by the Hawkins County Advisory Board. In addition there are two ex-officio

members by virtue of their positions of chairs of the Bristol and Holston Valley Advisory Boards. The chief executive officer of Wellmont serves on the Board as an *ex-officio* non-voting member.

The Directors serve on a voluntary basis and receive no compensation for their services. The names of the current Directors, their occupations and years of service are as follows:

Name/Title	Term Expires	Eligible for Another Term	Occupation
R. David Crockett Sr., chairman	06/30/2013	Yes - Through 6/30/2017	Consultant
T. Arthur Scott Jr., vice chairman	06/30/2014	Yes - Through 6/30/2018	Attorney
Julie Bennett, secretary	06/30/2013	Yes - Through 6/30/2017	Attorney
E. Wayne Kirk, treasurer/assistant secretary	06/30/2011	No	Certified Valuation Analyst and Certified Public Accountant
Robert Burgin	06/30/2013	Yes - Through 6/30/2017	Retired Hospital Administrator
Dr. Marvin Cameron	06/30/2012	ex-officio	Consultant
Denny DeNarvaez		by virtue of office	President and CEO
Dr. Pierre Istfan	06/30/2013	Yes - Through 6/30/2017	Cardiologist
Wayne Kennedy	06/30/2011	ex-officio	Retired Executive - Bristol Compressors
Ravan Krickbaum	06/30/2014	No	Retired - Superintendent of Rogersville City Schools
Roger Leonard	06/30/2013	Yes - Through 6/30/2017	Consultant
Roger K. Mowen Jr.	06/30/2012	Yes - Through 6/30/2016	Retired Executive Eastman Chemical Company
Dr. Thomas Pugh	06/30/2012	No	Radiologist
Glen "Skip" Skinner	06/30/2012	Yes - Through 6/30/2016	Administrator Wise County
Dr. Douglas Springer	06/30/2014	Yes - Through 6/30/2018	Gastroenterologist
Dr. David Thompson	06/30/2011	No	Internal Medicine Physician
John Williams	06/30/2014	Yes - Through 6/30/2018	CEO, Regional Eye Center

The Board delegates certain of its functions to several committees. Currently, the bylaws provide for five standing committees: Audit and Compliance; Governance; Human Resources; Finance and Investment; and Quality/Safety/Service. In addition to the five standing committees, the Board may appoint other committees from time to time. The committee responsible for oversight of Wellmont's financial operations is the Finance and Investment Committee. The Finance and Investment Committee is comprised of at least three trustees, and its purpose is to develop and monitor oversight of the operating and capital budgets and the investment portfolio of Wellmont. The Audit and Compliance Committee is responsible for oversight of Wellmont's financial reporting. Oversight responsibility of the Audit and Compliance Committee includes, but is not limited to: the integrity of financial statements, the financial reporting process, the systems of internal accounting and financial controls; the performance of a coordinated internal audit function; the performance of independent auditors; compliance with ethics policies; and compliance with legal and regulatory requirements.

Relationships with Board Members

Wellmont is permitted to enter into transactions from time to time with business organizations with which one or more of Wellmont's officers or Directors are affiliated. Pursuant to existing policy of the Board, such transactions or affiliations are permitted only after full disclosure of potential conflicts of interest to the Board and approval by a majority of the disinterested Directors. Interested Directors are not permitted to vote or to use personal influence on the matter and such Director is not counted in determining the quorum for a meeting when Board action is to be taken on the matter. The minutes of the meeting must reflect that a disclosure was made, the abstention from voting and the quorum satisfaction. There are currently no conflicts of interest with Directors relating to the Series 2011 Bonds.

Executive Management

Brief biographies of the executive management of Wellmont are set out below.

Margaret "Denny" DeNarvaez is president and CEO of Wellmont Health System. An accomplished executive with nearly 30 years of healthcare experience, DeNarvaez previously served as CEO of St. John's Mercy Health Care, which includes hospitals in both St. Louis and Washington, Mo. DeNarvaez also provided leadership for Mercy's extensive operations in Missouri and Oklahoma, encompassing more than 2,200 licensed beds, nearly 15,000 employees and nearly 3,000 physicians. During her five-year tenure with the Mercy system, DeNarvaez refocused the organization on its mission, vision and values, led a multimillion-dollar financial turnaround, established a dedicated heart hospital and developed a physician clinical council to leverage the experience and judgment of physicians in operations and planning. Under her leadership, St. John's Mercy was recognized as a "best place to work" by both the St. Louis Business Journal and Modern Healthcare magazine. DeNarvaez previously served as president of Abbott Northwestern Hospital in Minneapolis, part of Allina Hospitals and Clinics. Abbott Northwestern, the largest hospital in Minnesota's Twin Cities, is nationally recognized for clinical expertise in cardiac care through its renowned Minneapolis Heart Institute. She has also served as CEO and chief financial officer of Florida Medical Center in Fort Lauderdale, Fla. DeNarvaez is a graduate of Drake University in Fort Lauderdale, where she earned a bachelor's degree of business administration in accounting. She is a certified public accountant and holds leadership certifications from the University of Michigan Business School in Ann Arbor and the University of St. Thomas in St. Paul, Minn. She was the 2009 recipient of the Visionary Leadership Award from the Missouri Hospital Association and in 2007 was named one of the Top 25 most influential businesswomen by the St. Louis Business Journal.

Elizabeth "Beth" Ward is executive vice president and chief financial officer of Wellmont Health System. She was appointed to this role in 2010. Ms. Ward was previously employed as CFO and treasurer of Moses Cone Health System in Greensboro, N.C., a position she had held since 2001. She joined Moses Cone in 1996 as the first corporate controller and previously worked in leadership roles at the University of North Carolina at Chapel Hill's Division of Health Affairs and the University of North Carolina Hospitals. Ms. Ward is a graduate of Radford University in Virginia, where she received a bachelor's degree in business finance and insurance. She earned a master's degree in business administration from the University of North Carolina at Greensboro. She is a member of the Health Management Academy and the American Institute of Certified Public Accountants, as well as an advanced member of the Healthcare Financial Management Association. She is a certified public accountant in North Carolina and Tennessee and holds a leadership certification from the University of Michigan Business School in Ann Arber. She was named Business Woman of the Year by the Triad Business Journal in 2007 and CFO of the Year for Extra Large Organizations by the Triad Business Journal in August, 2009.

Tracey Moffatt is chief operating officer for Wellmont Health System. Moffatt, who has more than 25 years' experience as a clinical and operations leader, joined Wellmont in January, 2011. As COO, Moffatt provides strategic leadership across the health system in areas of clinical service delivery, performance and quality management and decision support. She previously was senior vice president of consulting for Navvis and Company, a national healthcare consulting firm. Previously, Moffatt was employed for nearly two decades by the Sisters of Mercy Health System in St. Louis. She held positions of increasing responsibility during her tenure there, culminating in her service as executive vice president of clinical performance/chief nurse executive for St. John's Mercy Health Care. Moffatt received her bachelor's degree in nursing from Louisiana State University Medical Center in New Orleans. She earned a master's degree in healthcare administration from Trinity University in San Antonio. She is a member of Sigma Theta Tau and in 2009 received the Missouri Hospital Association's Distinguished Quality Professional Award.

Patrick Kane, an Emmy-nominated producer with nearly 25 years' experience in advertising, marketing and communications, is senior vice president of marketing communications for Wellmont Health System. Before joining Wellmont in 2005, Mr. Kane served as director of marketing

communications for Conemaugh Health System in Johnstown, Pa. Prior to joining Conemaugh in 1997; he served as vice president and treasurer of Kane and Company Advertising Inc. in Johnstown. Mr. Kane is a graduate of Saint Joseph's College in Rensselaer, Ind., where he received a bachelor's degree in communications and theater arts, and King College in Bristol, Tenn., where he earned a master's degree in business administration.

Hamlin Wilson, senior vice president of human resources, joined the Wellmont Health System executive leadership staff in 2003. He has 22 years experience in health care, directing human resources functions for healthcare organizations in Tennessee and Mississippi. Mr. Wilson received his bachelor's degree at Southern Illinois University in Carbondale, Ill., and earned his master's degree at the University of Southern Mississippi in Hattiesburg, Miss. He holds advanced certification as a senior professional in human resources from the Society for Human Resource Management. He is a past president of the Tennessee Healthcare Human Resources Association and was honored by the American Society of Healthcare Human Resources Association when he received the Paul Guy Mentorship Award in 2003.

John Howard, an accomplished healthcare executive who holds doctorate and law degrees, serves as Wellmont Health System's general counsel and will help guide the organization's medical practice operations as of April 1, 2011. Mr. Howard worked for St. John's Mercy Health Care in St. Louis from 2001 to 2011. Most recently, he served as executive vice president and chief development officer. He was previously senior vice president, general counsel and assistant secretary. He also served as director of corporate compliance and privacy officer. Mr. Howard received a Bachelor of Arts degree in liberal studies from Concordia Lutheran College in Austin, Texas; a master's degree in English and philosophy from the University of Texas at Austin; a doctorate degree in English from St. Louis University; and a law degree from St. Louis University.

Todd Norris is executive director of the Wellmont Foundation and Wellmont Health System's senior vice president of institutional advancement. Mr. Norris is a graduate of East Tennessee State University, where he received his bachelor's and master's degrees. He has completed certificate programs through the Institute for Charitable Giving and Wharton's Institute for Higher Education Research. He is a member of the Council for Advancement and Support of Education, the Institute for Charitable Giving and the Association for Healthcare Philanthropy.

Virginia Frank is president of Holston Valley Medical Center. Ms. Frank previously served as administrator of the Heart and Vascular Hospital, a 96-bed facility that is part of St. John's Mercy Medical Center in St. Louis. She also served as vice president of operations for St. John's Mercy Medical Center. She previously worked as vice president of operations for Abbott Northwestern Hospital in Minneapolis and as chief information officer for Florida Medical Center Hospital in Fort Lauderdale, Fla. She earned a bachelor's degree in business administration from Florida Atlantic University in Boca Raton, Fla. She has also participated in the Global Leadership Development Program of the University of Michigan Business School.

Bart Hove, president of Bristol Regional Medical Center, is a graduate of Georgia Institute of Technology in Atlanta and the University of Alabama in Birmingham, where he received a master's degree in hospital administration. Before joining Bristol Regional in 2000, Mr. Hove was previously employed as chief executive officer of Delta Regional Medical Center in Greenville, Miss., CEO and president of Good Samaritan Hospital in Lexington, Ky., CEO of Crestwood Hospital in Huntsville, Ala., and administrator of Beaches Hospital in Jacksonville, Fla. He is a member of the American College of Hospital Administrators and the American Hospital Association.

David Brash serves as president of Lonesome Pine Hospital and regional vice president of Wellmont Health System hospitals in Southwest Virginia. Mr. Brash earned his bachelor's degree in

healthcare administration from West Virginia Institute of Technology and received his master's degree in healthcare administration from West Virginia College in Charleston. Prior to joining Mountain View, Brash served as the chief executive officer at Harlan Appalachian Regional Hospital in Kentucky, Russell County Medical Center in Lebanon, Va., and Plateau Medical Center in Oak Hill, W.Va. He has achieved fellow status with the American College of Healthcare Executives and is a member of the Virginia Hospital and Healthcare Association.

Fred Pelle, president of Hawkins County Memorial Hospital since 2005 and president of Hancock County Hospital since 2008, began his healthcare career in 1982 and has served in executive positions at hospitals in Alabama, Kentucky, Georgia and Virginia. Most recently, he served as CEO of Buchanan General Hospital in Grundy, Va. He is a graduate of Athens State College, where he earned a bachelor's degree in accounting, and Troy State University, where he received a master's degree in business administration. He is a fellow of the American College of Healthcare Executives and an advanced member of the Healthcare Financial Management Association.

Daniel Wolcott is president of Takoma Regional Hospital. Mr. Wolcott previously served as vice president of Florida Hospital Ormond Memorial and as administrator of Florida Hospital Oceanside, 205-bed and 119-bed hospitals, respectively, in Ormond Beach, Fla. He also previously served as director of patient financial services at Florida Hospital Ormond Memorial, and held the same title at Emory-Adventist Hospital in Smyrna, Ga. Mr. Wolcott received a master's degree in business administration with an emphasis in finance from Georgia State University. He earned a bachelor's degree in business administration/marketing from Southern Adventist University.

Tim Attebery is Senior Vice President of Cardiology Services for Wellmont Health System. Mr. Attebery has 26 years of healthcare consulting and senior management experience focused on cardiovascular services. From 1992 until 2010, he served as CEO at three different large cardiovascular group practices. Mr. Attebery managed the integration of Cardiovascular Associates and Wellmont Health System in 2010. He started CVI3, a national cardiovascular services consulting and training company in 2004 and sold that company in 2008. Mr. Attebery served on the Executive Committee and as President of the Cardiology Leadership Alliance, a national network of premier cardiology groups now known as MedAxiom. He organized the founding of the Society of Cardiovascular CT, which currently has over 5,000 international members and is recognized by the American College of Cardiology and the American Heart Association as the definitive, scientific organization for all cardiac CT matters.

MEDICAL STAFF

General. As of March 31, 2011, the combined medical staff of the Wellmont Health System consisted of 1,044 physicians with 932 or 89 percent being board certified. The average age of the medical staff was approximately 50 years.

	Active			Associate			Consulting			Courtesy			Affiliate			TOTAL		
	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total	Avg Age	Bd Cert	Total
Bristol Regional Medical Center	51	169	190	38	26	32	50	30	31	52	47	51	51	42	49	50	314	353
Holston Valley Medical Center	50	243	246	42	60	60	49	56	56	49	40	41	54	40	41	49	439	444
Mountain View Regional Medical Center	52	15	31							51	40	53				52	55	84
Lee Regional Medical Center	49	8	15				58	1	1	53	25	32				52	34	48
Lonesome Pine Hospital	56	14	21				49	40	41	51	50	63				51	104	125
Hawkins County Memorial Hospital/Hancock	47	21	24	46	6	6	51	21	21	50	52	64				49	100	115
TOTAL (Excludes Duplicates)	51	423	475	41	81	90	49	121	123	51	226	267	53	81	89	50	932	1,044

Discharges by Specialty. The following table lists Wellmont's discharges for fiscal years 2009 and 2010 by Specialty.

	FY 2009 Discharges	FY 2010 Discharges
Medical Services		
Cardiology	1,477	1,104
Dermatology	1	-
Endocrinology	2	2
General Medicine	12,899	11,583
Gastroenterology	145	109
Neurology	114	93
Nephrology	735	592
Oncology/Hematology	232	183
Pulmonary	392	307
Rheumatology	-	1
Subtotal	15,997	13,974
Surgical Services:		
Cardiovascular	847	877
General Surgery	3,295	2,808
Gynecology	186	212
Neurosurgery	892	854
Ophthalmology	-	1
Orthopedics	2,150	2,240
Otolaryngology	75	67
Plastic/Reconstructive	17	38
Urology	171	138
Thoracic	107	96
Trauma	601	649
Vascular	23	23
Subtotal	8,364	8,003
Hospitalist's Serviees	14,525	15,836
Women's & Pediatrics Services	3,657	3,556
Psychiatric Service	15	11
Totals	42,558	41,380

OTHER INFORMATION

Employees

Wellmont employs over 6,369 persons or 5,278 full time equivalents. Of these 113 are physicians. There are 389 part time employees or 251 full time equivalents. None of Wellmont's employees are represented by a labor union, nor is management aware of any union-organizing activities among its employees. Employee relations are considered to be excellent.

Insurance Coverage and Litigation

Wellmont maintains a self-insurance program that includes general and professional liability coverage for its entire operations. The insurance provides coverage in amounts consistent with those normally maintained by similar health care facilities.

Wellmont maintains a risk management program to avert and mitigate potential losses through early reporting and intervention. Claims are managed cooperatively between Wellmont's risk manager and Wellmont's primary insurance carrier.

Currently, there are no known claims against Wellmont with the potential of exceeding the limits of coverage available under the insurance plan.

Wellmont is involved in various liability disputes, governmental and regulatory inspections, inquiries, investigations, proceedings and litigation matters that arise from time to time in the ordinary course of business. Wellmont is self-insured with respect to professional liability, medical, dental and workers compensation claims and comprehensive general liability risks, subject to certain limitations. Professional and comprehensive general healthcare liability risks in excess of $1 million per occurrence are reinsured with major independent insurance companies up to an aggregate liability of $50 million.

Philanthropy

The Foundation seeks charitable donations from individuals, corporations, foundations and other organizations on behalf of Wellmont. The Foundation has established programs in major gifts, planned giving, annual gifts, tribute and memorial gifts, and in-kind gifts.

Licenses, Accreditation and Approvals

The Health System's hospitals are licensed by the respective States in which they operate and are accredited by The Joint Commission. The Joint Commission's accreditation process seeks to help organizations identify and correct problems to improve the safety and quality of care and services provided. The process focuses on systems critical to the safety and quality of care, treatment and services.

The Health System's laboratories hold medical test site licenses issued by the respective States in which they operate and are accredited by the College of American Pathologists.

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APPENDIX B.

FINANCIAL STATEMENTS OF THE CORPORATION

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KPMG

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2010 and 2009

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

Table of Contents

KPMG LLP
Suite 1000
401 Commerce Street
Nashville, TN 37219-2422

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

We have audited the accompanying consolidated balance sheets of Wellmont Health System and affiliates (Wellmont) 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 Wellmont'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 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 Wellmont's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that 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 consolidated financial position of Wellmont Health System and affiliates as of June 30, 2010 and 2009, and the consolidated results of their operations and changes in net assets, and cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

October 28, 2010

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2010 and 2009

(Dollars in thousands)

Assets		2010	2009
Current assets:			
Cash and cash equivalents	$	35,711	60,889
Assets limited as to use, required for current liabilities		1,815	2,201
Patient accounts receivable, less allowance for uncollectible accounts of approximately $25,113 and $27,890 in 2010 and 2009, respectively		94,057	98,071
Other receivables		10,919	11,173
Inventories		18,294	17,169
Prepaid expenses and other current assets		7,003	6,040
Total current assets		167,799	195,543
Assets limited as to use, net of current portion		301,807	245,600
Land, buildings, and equipment, net		450,205	442,610
Other assets:			
Long-term investments		32,391	31,974
Investments in affiliates		32,019	31,976
Deferred debt expense, net		4,644	4,824
Goodwill, net		9,501	9,509
Other		730	798
		79,285	79,081
Total assets	$	999,096	962,834
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	11,958	13,197
Lines of credit/short-term note payable		14,000	15,811
Accounts payable and accrued expenses		74,679	77,139
Estimated third-party payor settlements		11,672	12,441
Current portion of other long-term liabilities		7,251	6,352
Total current liabilities		119,560	124,940
Long-term debt, less current portion		467,833	474,608
Other long-term liabilities, less current portion		47,364	38,422
Total liabilities		634,757	637,970
Net assets:			
Unrestricted		358,620	320,030
Temporarily restricted		4,551	3,589
Permanently restricted		1,168	1,245
Total net assets		364,339	324,864
Commitments and contingencies			
Total liabilities and net assets	$	999,096	962,834

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2010 and 2009

(Dollars in thousands)

	2010	2009
Revenue:		
Net patient service revenue	$ 692,920	680,056
Other revenues	31,472	27,842
Total revenue	724,392	707,898
Expenses:		
Salaries and benefits	310,667	323,801
Medical supplies and drugs	150,143	141,044
Purchased services	74,922	81,031
Interest	20,110	16,013
Provision for bad debts	35,293	33,402
Depreciation and amortization	43,711	42,957
Other	66,734	62,604
Total expenses	701,580	700,852
Income from operations	22,812	7,046
Nonoperating gains (losses):		
Investment income	1,012	4,181
Derivative valuation adjustments	(2,693)	(5,747)
Other, net	(1,870)	(625)
Nonoperating losses, net	(3,551)	(2,191)
Revenue and gains in excess of expenses and losses before discontinued operations	19,261	4,855
Discontinued operations	(1,109)	(4,455)
Revenue and gains in excess of expenses and losses	18,152	400
Other changes in unrestricted net assets:		
Change in net unrealized gains (losses) on investments	22,312	(60,663)
Net assets released from restrictions for additions to land, buildings, and equipment	1,555	2,758
Change in the funded status of benefit plans and other	(3,429)	(13,568)
Increase (decrease) in unrestricted net assets	38,590	(71,073)
Changes in temporarily restricted net assets:		
Contributions	2,934	1,944
Net assets released from temporary restrictions	(1,972)	(3,154)
Increase (decrease) in temporarily restricted net assets	962	(1,210)
Changes in permanently restricted net assets – investment (loss) income	(77)	645
Change in net assets	39,475	(71,638)
Net assets, beginning of year	324,864	396,502
Net assets, end of year	$ 364,339	324,864

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2010 and 2009

(Dollars in thousands)

	2010	2009
Cash flows from operating activities:		
Change in net assets	$ 39,475	(71,638)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	43,755	43,393
Loss on disposal of land, buildings, and equipment	1,282	659
Equity in gain of affiliated organizations	(6,773)	(5,549)
Amortization of deferred financing costs	180	238
Net realized and unrealized (gains) losses on investments, other than trading	(17,994)	66,199
Provision for bad debts	35,950	33,821
Change in fair value of derivative instruments	2,693	5,747
Changes in assets and liabilities:		
Patient accounts receivable	(31,936)	(22,378)
Other current assets	(2,088)	(385)
Other assets	322	3,735
Accounts payable and accrued expenses	2,722	(5,796)
Estimated third-party payor settlements	(769)	10,355
Other current liabilities	899	1,437
Other liabilities	7,933	11,101
Net cash provided by operating activities	75,651	70,939
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	88,887	67,580
Purchase of investments	(127,131)	(25,207)
Purchase of land, buildings, and equipment	(55,684)	(86,623)
Proceeds from the sale of buildings and equipment	4,357	31,251
Cash paid for acquisitions	(2,421)	—
Investment in affiliated organizations	—	(4,453)
Distributions from affiliated organizations	6,730	7,181
Distributions to affiliated organizations	(1,684)	(924)
Net cash used in investing activities	(86,946)	(11,195)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	14,000	484
Payments on long-term debt	(12,083)	(11,005)
Payments on line of credit	(15,800)	(2,121)
Net cash used in financing activities	(13,883)	(12,642)
Net (decrease) increase in cash and cash equivalents	(25,178)	47,102
Cash and cash equivalents, beginning of year	60,889	13,787
Cash and cash equivalents, end of year	$ 35,711	60,889

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of $1,290 and $18,050 in 2010 and 2009, respectively.

Additions to property and equipment financed through current liabilities of $5,182 and $5,977 in 2010 and 2009, respectively.

See accompanying notes to consolidated financial statements.

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont) was formed to assume operations of Bristol Regional Medical Center (BRMC) and Holston Valley Health Care, Inc. (HVHC), including Holston Valley Medical Center, Inc. (HVMC), and to act as sole corporate member of its consolidated foundations. Effective July 1, 1996, under terms of an agreement and plan of consolidation and merger, BRMC and HVHC, including HVMC, were merged and consolidated into Wellmont. Effective January 1, 1997, Lonesome Pine Hospital (LPH), a Virginia corporation, was merged into Wellmont under terms of a plan of merger and merger agreement. Effective July 1, 2000, Hawkins County Memorial Hospital (HCMH) transferred its operations and operating assets to Wellmont Hawkins County Memorial Hospital (WHCMH), a tax-exempt organization that is wholly owned and controlled by Wellmont. Hancock County Hospital (HCH), a critical access hospital, was opened in March 2005 to help provide for the immediate healthcare needs of the residents of Sneedville and the surrounding counties. As of July 16, 2007, Wellmont acquired Jenkins Community Hospital (Jenkins) in Kentucky. As of August 1, 2007, Wellmont acquired two hospitals in Virginia, Lee Regional Medical Center in Pennington Gap and Mountain View Regional Medical Center in Norton. On May 30, 2008, Wellmont acquired the Holston Valley Cath Lab, an outpatient lab. On May 1, 2010, Wellmont acquired Cardiovascular Associates.

As of April 30, 2009, Wellmont closed Jenkins, sold the majority of the facility's property and equipment to Appalachian Regional Healthcare, Inc for $1,000 and recorded a loss on sale of approximately $256. The consolidated financial statements for the years ended June 30, 2010 and 2009 present Jenkins as a discontinued operation. The operating losses of $474 and $3,659 for the years ended June 30, 2010 and 2009, respectively, and the impairment are included in the classification of discontinued operations.

As of June 30, 2010, it was announced that Wellmont will sell the majority of Medical Mall Pharmacy's assets to a national pharmacy company for $1,300 plus inventory value. The consolidated financial statements for the years ended June 30, 2010 and 2009 present Medical Mall Pharmacy as a discontinued operation. The operating losses of $635 and $540 for the years ended June 30, 2010 and 2009, respectively, are included in the classification of discontinued operations. The sale was completed on September 23, 2010.

All acute care operations remain separately licensed and are treated as operating divisions within Wellmont. Wellmont's operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

The consolidated financial statements include the acute care operations of the above entities along with:

- Wellmont Foundation (the Foundation), which was created from the merger of Bristol Regional Medical Center Foundation and Holston Valley Health Care Foundation, Inc. The Foundation conducts fund-raising activities for the benefit of Wellmont.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate a pharmacy and physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

- The Alzheimer's Center of East Tennessee was merged into Wellmont and changed its name to Wellmont Madison House effective September 1, 1997. Wellmont is the sole corporate member and the consolidated financial statements include the operations of this entity.

All significant intercompany accounts and transactions have been eliminated in the accompanying consolidated financial statements.

(2) Significant Accounting Policies

A summary of significant accounting policies follows:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) 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. Significant estimates include: allowances for contractual adjustments and bad debts; third-party payor settlements; valuation of investments, land, buildings, equipment, and goodwill; and self-insurance and other liabilities. Actual results could differ from these estimates.

(b) Cash and Cash Equivalents

Wellmont considers all highly liquid investments with a maturity of three months or less when purchased, excluding amounts whose use is limited by board of director's designation or other arrangements under trust agreements, to be cash equivalents.

(c) Investments

Marketable equity securities and debt securities are recorded at fair value and classified as other than trading. Fair value is determined primarily using quoted prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date. However, Wellmont also uses observable and unobservable inputs for investments without quoted market prices to determine the fair value of certain investments at the measurement date. Investments in limited partnerships are recorded at fair value as determined by the partnership using net asset value. Wellmont elected to early adopt the measurement provisions of Accounting Standards Update No. 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent),* to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. Investments in affiliates in which Wellmont has significant influence but does not control are reported on the equity method of accounting, which represents Wellmont's equity in the underlying net book value. Long-term investments include those investments that have not been designated by the board of directors for specific purposes and are also not intended to be used for the liquidation of current liabilities. Investment income is recognized when earned.

Realized gains and losses are determined on the specific-identification method and included in investment income with interest and dividends. Investment income is reported net of related investment fees. Unrealized gains and losses are included in other changes in unrestricted net assets except for losses determined to be other than temporary, which are considered realized losses and included in investment income.

On July 1, 2008, Wellmont adopted new guidance issued by the Financial Accounting Standards Board (FASB), which defines fair value, establishes a framework for the measurement of fair value, and enhances disclosures about fair value measurements now codified into Accounting Standards Codification (ASC) 850. ASC 850 statement does not require any new fair value measures and did not have a material impact on Wellmont's consolidated financial statements for the year ended June 30, 2009, however, expanded fair value disclosures have been provided in note 19.

(d) Assets Limited as to Use

Assets limited as to use primarily include assets held by trustees under bond indenture and self-insurance agreements, as well as designated assets set aside by the board of directors for future capital improvements, over which the board of directors retains control and may, at its discretion, subsequently use for other purposes. Amounts required to meet current liabilities of Wellmont have been reclassified to current assets in the accompanying consolidated balance sheets.

(e) Inventories

Inventories are stated at the lower of cost or market value and are valued principally by the first-in, first-out, and average-cost methods.

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, if purchased, or fair value at date of donation. Depreciation is computed using the straight-line method based on the estimated useful life of the asset, ranging from 3 to 40 years. Buildings and equipment held under capital leases are recorded at net present value of future lease payments and are amortized on a straight-line basis over the shorter of the lease term or estimated useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Upon sale or retirement of land, buildings, or equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss, if any, is included in other revenues on the consolidated statements of operations and changes in net assets. 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.

Wellmont evaluates long-lived assets for impairment on annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows

(Dollars in thousands)

expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset.

(g) Goodwill

Goodwill represents the difference between the cost of net assets acquired and estimated fair value at purchase date, and is being amortized using the straight-line method over periods of 5 to 15 years. For goodwill acquired by its taxable entities, the FASB has implemented a nonamortization approach to goodwill. However, the effective date for not-for-profit entities is not effective until fiscal year 2011 for Wellmont and, as such, Wellmont continues to amortize the goodwill associated with its tax-exempt entities. Wellmont assesses the recoverability and the amortization period of goodwill for not-for-profit entities by determining whether the amount can be recovered through undiscounted cash flows of the business acquired, excluding interest and amortization, over the remaining amortization period. If impairment is indicated by this analysis, measurement of the impairment recognized is based on the difference between the fair value and the carrying amount of the asset. Management considers external factors relating to each acquired business, including local market developments, regional and national trends, regulatory developments, and other pertinent factors in making its assessment. Goodwill for Wellmont's for-profit/taxable entities is reviewed for impairment at least annually in accordance with the provisions of FASB ASC 350, *Intangibles – Goodwill and Other* (Statement No. 142, *Goodwill and Other Intangible Assets*). The goodwill impairment test is a two-step test. Under the first step, the fair value of the reporting unit is compared with its carrying value (including goodwill). If the fair value of the reporting unit is less than its carrying value, an indication of goodwill impairment exists for the reporting unit and the enterprise must perform step two of the impairment test. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. A summary of goodwill and related amortization for the years ended June 30 follows:

	2009	Additions	Decreases	2010
Goodwill	$ 12,604	—	—	12,604
Amortization	(3,095)	(8)	—	(3,103)
	$ 9,509	(8)	—	9,501

(Continued)

(Dollars in thousands)

	2008	Additions	Decreases	2009
Goodwill	$ 12,771	—	(167)	12,604
Amortization	(3,130)	(30)	65	(3,095)
	$ 9,641	(30)	(102)	9,509

(h) Deferred Debt Expense

Deferred debt expense is amortized over the life of the related bond issues using the effective-interest method.

(i) Derivative Financial Instruments

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) Asset Retirement Obligations

Asset retirement obligations (AROs) are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value, and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, Wellmont records period-to-period changes in the ARO liability resulting from the passage of time and revisions to either the timing or the amount of the original estimate of undiscounted cash flows. Wellmont derecognizes ARO liabilities when the related obligations are settled.

(k) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by Wellmont has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by Wellmont in perpetuity. Generally, donors of permanently restricted assets permit use of all or part of the income earned on related investments for general or specific purposes.

Temporarily restricted net assets relate primarily to amounts held by the Foundation and include amounts restricted for future capital expenditures and for operations of such areas as children's healthcare services, hospice, and cancer research.

(Continued)

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2010 and 2009 primarily included amounts related to the purchase of buildings and equipment for pediatrics, cancer, and other healthcare operations.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

Patient accounts receivable are reported net of both an allowance for uncollectible accounts and an allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, TennCare, Medicaid, and other third-party payment programs. Wellmont's policy does not require collateral or other security for patient accounts receivable. Wellmont routinely obtains assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans, or policies.

(m) Revenue and Gains in Excess of Expenses and Losses

The consolidated statements of operations and changes in net assets include revenue and gains in excess of expenses and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include changes in net unrealized gains (losses) on investments other-than-trading securities, changes in the funded status of Wellmont's defined benefit plans, contributions of long-lived assets, including assets acquired using contributions that, by donor restriction, were to be used for the purpose of acquiring such assets, and cumulative effects of changes in accounting principles.

For purposes of financial statement display, those activities directly associated with Wellmont's mission of providing healthcare services are considered to be operating activities. Nonoperating activities primarily include investment and related activities. Other operating revenues primarily include cafeteria, rental, and income from affiliates.

(n) Contributed Resources

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted contributions, and are excluded from revenue and gains in excess of expenses and losses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit

donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. Gifts are reported as either a temporarily or permanently restricted contribution if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions. Unrestricted contributions are included in other revenues.

(o) Federal Income Taxes

The Wellmont entities are primarily classified as organizations exempt from federal income taxes under Section 501(a) as entities described in Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been included for these entities in the consolidated financial statements. The operations of Wellmont, Inc. and its subsidiaries are subject to state and federal income taxes, which are accounted for in accordance with ASC 740, *Income Taxes*; however, such amounts are not material.

On July 1, 2007, Wellmont adopted new guidance issued by on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

(p) New Accounting Pronouncements

Effective July 1, 2008, Wellmont adopted new guidance issued by FASB, which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA) now codified into ASC 958, *Not-for-Profit Entities*. Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of four individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a

manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

On June 30, 2009, Wellmont adopted guidance issued by the FASB for subsequent events, now codified into ASC 855, *Subsequent Events*. ASC 855 defines the period after the balance sheet date during which management shall evaluate events or transactions that may occur for potential recognition or disclosure, the circumstances under which an organization shall recognize events occurring after the balance sheet date and the disclosures that an organization shall make about those events or transactions. ASC 855 defines two types of subsequent events. The first type consists of events or transactions that provide additional evidence about conditions that existed at the date of the balance sheet, including the estimates inherent to the process of preparing financial statements (i.e., recognized subsequent events). The second type consists of events that provide evidence about conditions that did not exist at the date of the balance sheet but arose after the date (i.e., nonrecognized event).

Management evaluated all events and transactions that occurred through October 28, 2010. Other than described in note 11, Wellmont did not have any material subsequent events during this period.

On July 1, 2009, the FASB issued Statement No. 168, *The FASB Accounting Standards Codification™ and the Hierarchy of Generally Accepted Accounting Principles* (Statement 168). Statement 168 is the single source of authoritative nongovernmental GAAP, superseding existing FASB, American Institute of Certified Public Accountants, Emerging Issues Task Force, and related accounting literature. Statement 168 reorganizes the thousands of pages of GAAP pronouncements into roughly 90 accounting topics and displays them using a consistent structure. Also included is relevant Securities and Exchange Commission guidance organized using the same topical structure in separate sections. Statement 168 is effective for interim and annual periods ending after September 15, 2009. The adoption of Statement 168 had no significant effect on the Wellmont's consolidated financial statements.

(q) Reclassifications

Certain 2009 amounts have been reclassified to conform to the 2010 consolidated financial statement presentation.

(Dollars in thousands)

(3) 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 consolidated statements of operations and changes in net assets is as follows for the years ended June 30:

	2010	2009
Gross patient service charges	$ 2,158,847	2,178,018
Less:		
Contractual adjustments and other discounts	(1,411,435)	(1,440,519)
Charity care	(54,492)	(57,443)
	(1,465,927)	(1,497,962)
Net patient service revenue	$ 692,920	680,056

(4) Third-Party Reimbursement Arrangements

Wellmont renders services to patients under contractual arrangements with the Medicare and Medicaid programs. The Medicaid program in Tennessee was replaced with a managed care program known as TennCare, which was designed to cover previous Medicaid eligible enrollees. Amounts earned under these contractual arrangements are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Management believes that adequate provision has been made for any adjustments that may result from such reviews. Participation in these programs subjects Wellmont to significant rules and regulations; failure to adhere to such could result in fines, penalties, or expulsion from the programs.

Wellmont contracts with various managed care organizations under the TennCare program. TennCare reimbursement for both inpatient and outpatient services is based upon prospectively determined rates, including diagnostic-related group assignments, fee schedules, and per diem amounts. Reimbursement under the Virginia Medicaid program is also based upon prospectively determined amounts.

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid-eligible and other low income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

(Continued)

(Dollars in thousands)

Net patient service revenue in 2010 and 2009 related to Medicare, TennCare, and Virginia Medicaid and net patient accounts receivable at June 30, 2010 and 2009 from Medicare, TennCare, and Virginia Medicaid were as follows:

		2010	2009
Net patient service revenue:			
Medicare	$	277,372	272,259
TennCare		22,918	22,509
Virginia Medicaid		23,536	19,036
Net patient accounts receivable:			
Medicare	$	41,125	39,852
TennCare		2,206	4,072
Virginia Medicaid		3,739	3,172

Wellmont has filed cost reports with Medicare and Virginia Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Virginia Medicaid cost reports have been audited by the intermediary through June 30, 2006.

Wellmont has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, per diem rates, and discounts from established charges.

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased (decreased) approximately $863 and $(2,600) in 2010 and 2009, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of final settlements, and years that are not longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2010 could differ materially from actual settlements based on the results of third-party audits.

(5) Charity Care and Community Services

Wellmont accepts all patients within its primary service area regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies that consider, among other factors, generally recognized poverty income levels.

Wellmont maintains records to identify and monitor the level of charity care it provides. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were $54,492, $15,567, and

(Dollars in thousands)

2.52%, respectively, for the year ended June 30, 2010 and $57,443, $16,203, and 2.63%, respectively, for the year ended June 30, 2009.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled $55,461 and $57,212 for the years ended June 30, 2010 and 2009, respectively.

Wellmont also provides services to the community at large for which it receives little or no payment. Health evaluations, screening programs, and specific services for the elderly and homebound are other services supplied. Wellmont also provides public health education, trains new health professionals, and conducts health research.

(6) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in net income of affiliates was approximately $6,773 and $5,549 for the years ended June 30, 2010 and 2009, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont made additional contributions of $0 and $4,453 during 2010 and 2009, respectively, to affiliates, which increased Wellmont's overall investment in affiliates. Wellmont received distributions of $6,730 and $7,181 during 2010 and 2009, respectively, which reduced Wellmont's overall investment in the affiliates.

The following table summarizes the unaudited aggregate financial information of Wellmont's investments in affiliates:

		2010	2009
Total assets	$	129,720	137,737
Total liabilities		13,943	39,913
Total net assets	$	115,777	97,824
Net revenues	$	166,815	178,253
Expenses		142,534	159,004
Revenues in excess of expenses	$	24,281	19,249

(Continued)

(Dollars in thousands)

Wellmont's equity investment in these affiliates and its ownership percentage as of June 30, 2010 and 2009 are as follows:

	Amount		Percentage	
	2010	2009	2010	2009
Takoma Regional Hospital	$ 12,645	12,302	60%	60%
Holston Valley Imaging Center (HVIC)	8,048	9,047	75	75
Advanced Home Care (AHC)	6,092	6,092	6	6
Spectrum Tennessee Network	3,850	3,462	20	20
Others	1,384	1,073	4% – 50%	4% – 50%
	$ 32,019	31,976		

Wellmont provided billing and management services to the affiliates. Income recognized by Wellmont for the services was $1,766 in 2010 and $1,501 in 2009 and is included in other revenues.

Included in other receivables are $124 and $135 as of June 30, 2010 and 2009, respectively, of amounts due to Wellmont from these entities.

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

(Dollars in thousands)

(7) Investments

Long-term investments, including assets limited as to use, at June 30 are reported at fair value and consist of the following:

		2010	2009
Assets limited as to use by Board for capital improvements:			
Stock mutual funds	$	109,629	108,036
Bond mutual funds		71,698	5,910
Cash and money market funds		1,474	2,517
Real estate funds		7,468	5,419
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):			
Liquid		33,915	12,415
Illiquid		23,490	23,171
		247,674	157,468
Assets limited as to use under self-insurance agreements:			
Corporate bonds		6,867	7,464
Cash and money market funds		558	643
		7,425	8,107
Assets limited as to use under bond indenture agreements:			
Cash and money market funds		48,523	82,226
Less assets limited as to use that are required for current liabilities		1,815	2,201
Assets limited as to use, net of current portion	$	301,807	245,600
Long-term investments:			
Stock mutual funds	$	9,279	8,631
Bond mutual funds		7,599	3,648
Preferred equity investment and related options		11,512	11,512
Cash, money market funds, and certificates of deposit		287	5,202
Real estate funds		1,722	1,255
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):			
Liquid		1,992	1,726
Total long-term investments	$	32,391	31,974

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately $12,112 as of June 30, 2010 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which $417 was paid subsequent to June 30, 2010.

(Continued)

(Dollars in thousands)

Wellmont has invested $10,000 in the preferred equity of a regional managed services organization and $1,512 on a right of first refusal related to any future sale of this organization. This equity has a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

Wellmont's investments are concentrated in stock and bond mutual funds. In the event of a downward trend in the stock and bond markets, Wellmont's overall market value of net assets could be adversely affected by a material amount. Investments in alternative investments are generally illiquid investments whose value is determined by the general partner such as hedge funds, private equity, commingled funds, and real estate funds. Distributions are only at the discretion of a voting majority of the general partners.

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, the Company recognized other-than-temporary impairment losses of $8,233 and $4,654 on investments as of June 30, 2010 and 2009, respectively. The unrealized losses on these mutual funds were primarily caused by the overall decline in the world's economy in 2009 and 2010. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2010 and 2009, were as follows:

	June 30, 2010					
	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
Alternative investments	$ —	—	910	4,219	910	4,219
Stock mutual funds	2,184	29,658	24,817	83,713	27,001	113,371
	$ 2,184	29,658	25,727	87,932	27,911	117,590

	June 30, 2009					
	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
Bond mutual funds	$ 191	4,112	—	—	191	4,112
Alternative investments	5,525	16,227	4,144	7,120	9,669	23,347
Stock mutual funds	22,243	74,147	17,460	35,983	39,703	110,130
	$ 27,959	94,486	21,604	43,103	49,563	137,589

(Dollars in thousands)

Investment income is comprised of the following for the years ended June 30:

	2010	2009
Interest and dividends, net of amounts capitalized	$ 5,330	9,717
Realized losses on investments, including $8,233 and $4,654 recognized losses related to other-than-temporary impairments in 2010 and 2009, respectively.	(4,318)	(5,536)
Investment income, net	$ 1,012	4,181
Change in net unrealized gains (losses) on investments	$ 22,312	(60,663)

(8) Land, Buildings, and Equipment

Land, buildings, and equipment at June 30 consist of the following:

	2010	2009
Land	$ 41,210	44,149
Buildings and improvements	488,285	392,593
Equipment	327,896	303,805
Buildings and equipment under capital lease obligations	39,591	38,734
	896,982	779,281
Less accumulated depreciation	(459,935)	(418,399)
	437,047	360,882
Construction in progress	13,158	81,728
Land, buildings, and equipment	$ 450,205	442,610

Depreciation expense for the years ended June 30, 2010 and 2009 was $43,755 and $43,393, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was $13,266 and $9,109 as of June 30, 2010 and 2009, respectively.

(Continued)

(Dollars in thousands)

(9) Other Long-Term Liabilities

Other long-term liabilities at June 30 consist of the following:

	2010	2009
Workers' compensation liability	$ 6,606	5,706
Professional and general liability	11,183	9,494
Postretirement benefit obligation	5,861	5,653
Asset retirement obligation	3,710	3,621
Deferred gain on sale of assets	1,382	2,136
Derivative liability	12,943	10,250
Pension benefit liability	10,018	6,709
Other	2,912	1,205
	54,615	44,774
Less current portion	(7,251)	(6,352)
Total other long-term liabilities	$ 47,364	38,422

(10) Lines of Credit/Notes Payable

During 2008, Wellmont entered into three lines of credit for $15,000, $1,800, and $10,000. The $15,000 line of credit had a variable interest rate based upon LIBOR plus 1% and a termination date of August 2009; at June 30, 2009, $14,000 was outstanding on this line. During 2010, the $15,000 line of credit was paid in full with a $14,000 note payable, which was initiated with one bank to pay off the line of credit. The $14,000 note payable has a variable interest rate based upon LIBOR plus 2% and a termination date of December 2010. At June 30, 2010, $14,000 was outstanding on this note. During 2008, a $1,800 line of credit was initiated with one bank and was paid in full with the funds from the $10,000 line of credit from another bank, which had variable interest rate based upon LIBOR plus 0.95% and a termination date of August 31, 2009; at June 30, 2010 and 2009, $0 and $1,811, respectively, was outstanding on this line. The $10,000 line of credit was paid in full in 2010.

(Continued)

(Dollars in thousands)

(11) Debt

(a) Long-Term Debt

Long-term debt consists of the following at June 30:

	2010	2009
Hospital Revenue Bonds, Series 2007A	$ 55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2006A and 2006B	93,405	95,205
Hospital Revenue Refunding Bonds, Series 2005	61,810	63,940
Hospital Revenue Bonds, Series 2003	36,666	40,145
Notes payable	6,429	4,399
Capital lease obligations	19,698	22,388
Other	358	71
	473,366	481,148
Unamortized premium	7,538	7,800
Unamortized discount	(1,113)	(1,143)
	479,791	487,805
Less current maturities	(11,958)	(13,197)
	$ 467,833	474,608

(b) Series 2007 Bonds

On July 24, 2007, The Virginia Small Business Financing Authority issued, on behalf of Wellmont, $55,000 of Hospital Revenue Bonds, Series 2007A. The Series 2007A Bonds, with other methods of financing, were used to purchase the assets of Mountain View Regional Medical Center and Lee Regional Medical Center.

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $360 to $2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of $29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.25%.

(c) Series 2006C

On October 26, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, $200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to: finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the

construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation, and equipping of an operating room and related facilities at HCMH.

Principal on outstanding Series 2006C Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,605 to $25,330 commencing on September 1, 2017 through September 1, 2036. The outstanding bonds accrue interest at rates ranging from 5.00% to 5.25%.

(d) Series 2006 A and B

On June 23, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, $98,475 of Hospital Revenue Refunding Bonds, Series 2006. This bond issuance consists of Series A tax-exempt and Series B taxable bonds of $76,595 and $21,880, respectively. The Series 2006 Bonds together with other available funds were used to advance refund all the previously issued Hospital Revenue Bonds, Series 1993, to reimburse Wellmont for payments made on other taxable borrowings and to pay certain expenses incurred in connection with the issuance of the Series 2006 Bonds. Upon this refunding, a trust was established to pay all future bond payments related to the Series 1993 Bonds. Wellmont was deemed to have paid the Series 1993 Bonds and these Bonds are no longer deemed to be outstanding for purposes of the Series 1993 Trust Indenture.

Principal on outstanding Series 2006A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $875 to $6,400 commencing on September 1, 2013 through September 1, 2032; and the outstanding bonds accrue interest on a variable rate, which is reset monthly based upon the AAA-insured Municipal Market Data Index, plus 85 basis points. Principal on outstanding Series 2006B Bonds is payable through maturity in annual amounts ranging from $1,600 to $2,930 commencing on September 1, 2007 through September 1, 2016, and the outstanding bonds accrue interest at a fixed rate of 6.95%.

Outstanding Series 2006A Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%–102% of the principal amount of the Series 2006A Bonds being redeemed, plus accrued interest thereon to the redemption date.

On October 1, 2010, the Series 2006B Bonds were called and paid in full at par value of $14,880.

(e) Series 2005

On December 8, 2005, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

Principal on outstanding Series 2005 Bonds is payable through maturity or scheduled mandatory sinking fund redemption in annual amounts ranging from $1,945 to $3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a "best efforts" basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. Subsequent to year-end, Wellmont amended its letter of credit to cover an amount equal to the principal and up to 40 days' interest on the bonds at a maximum interest rate of 12% per annum, and is effective through July 1, 2011. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate for the first 90 days equal to the greater of (i) the Prime Rate plus 1.50% per annum, ii) the Federal Funds Rate plus 3.00% per annum, or iii) 7.50% per annum. ; the Base Rate plus 0.50% for days 91 through 366 and the Base Rate plus 1.00% thereafter until the amount is paid in full.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%–102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(f) Series 2003

On June 1, 2003, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, $59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont's Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of $27,460 in fixed rate serial bonds and $19,280 in fixed rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from $3,230 on September 1, 2007 to $4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

(g) Master Trust Indenture

The master trust indenture and loan agreements for the 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their

obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

Funds held by the trustee related to the various revenue bonds are available for specific purposes. The bond interest and revenue funds may be used only to pay interest and principal on the bonds; the debt service reserve fund may be used to pay interest and principal if sufficient funds are not available in the bond interest and revenue funds. The original issue discount and premium on all Bond Series outstanding are being amortized over the life of the bond issue using the effective-interest method.

(h) Notes Payable

During 2007, Wellmont entered into a five-year $3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011; at June 30, 2010 and 2009, $2,062 and $2,319, respectively, was outstanding on this note.

During 2008, Wellmont entered into a five-year $2,400 term note payable, which has a fixed interest rate of 7.25% and a termination date of August 2012; at June 30, 2010 and 2009, $1,600 and $2,080, respectively, was outstanding on this note.

During 2010, Wellmont entered into a $2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable has a fixed interest rate of 5.5% and a termination date of May 2013. At June 30, 2010, $2,767 was outstanding on this note.

(i) Capital Lease Obligations

Wellmont has entered into leases for certain equipment under agreements classified as capital leases that expire over periods through 2011. Assets under capital leases are included in property and equipment and have a net carrying value of $26,325 and $29,625 as of June 30, 2010 and 2009, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 4.3% to 6.0%.

(Dollars in thousands)

(j) Long-term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2010 are as follows:

2011	$	11,958
2012		13,329
2013		12,935
2014		12,193
2015		12,415
Thereafter		410,536
	$	473,366

The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2011	$	11,958
2012		30,859
2013		30,365
2014		29,508
2015		9,755
Thereafter		360,921
	$	473,366

Interest paid for the years ended June 30, 2010 and 2009 was $20,792 and $21,564, respectively, net of amounts capitalized. Interest costs of $2,776 and $3,421, net of interest income of $683 and $3,293 in 2010 and 2009, respectively, were capitalized.

(12) Derivative Transactions

Interest Rate Swaps: Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to postcollateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and

(Dollars in thousands)

Wellmont's bond rating. As of June 30, 2010 and 2009, Wellmont was not required to postcollateral related to its swaps.

Market risk is the adverse effect on the value of a derivative instrument that results from a change in interest rates. The market risk associated with interest-rate contracts is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

In September and October 2008, the counterparty and credit support provider to the swaps filed bankruptcy. Subsequent to the bankruptcy filings, no payments have been made by Wellmont or the counterparty to each other. As of June 30, 2010, the net amounts due to Wellmont for this period are less than $100 and have been fully reserved. The bankruptcy process is underway and the outcome cannot be determined at this time.

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its debt structure using LIBOR. The fair value as of June 30, 2010 and 2009 of approximately $(12,943) and $(10,250), respectively, is included in other liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately $(2,693) and $(5,747), respectively, in 2010 and 2009 and is included in nonoperating losses, net in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The net amounts have been recorded pending the outcome of any bankruptcy proceedings. The following is a summary of the interest rate swap information as of June 30, 2010:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2006A	$ 76,595	June 29, 2006	September 1, 2011	1.103%	5.440%	$ 1,101
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.217	(6,810)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	0.253	0.198	(2,710)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	0.162	(4,524)
							$ (12,943)

The following is a summary of the interest rate swap information as of June 30, 2009:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2006A	$ 76,595	June 29, 2006	September 1, 2011	2.744%	5.884%	$ 1,075
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.309	(5,197)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	1.894	1.728	(2,708)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	1.184	(3,420)
							$ (10,250)

(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was $9,990 and $9,937 for the years ended June 30, 2010 and 2009, respectively.

HVMC sponsored a noncontributory, defined benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined benefit pension plan covering substantially all its employees.

HVMC's defined pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined pension plan exists. Collectively, the two defined benefit plans are referred to as the "Plans."

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined benefit pension plans as an asset or liability in its consolidated balance sheets and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined benefit pension plans use a June 30 measurement date.

(Continued)

(Dollars in thousands)

The following table sets forth the funded status of the combined Plans, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		2010	2009
Change in benefit obligation:			
Benefit obligation at beginning of year	$	40,035	37,212
Service cost		230	234
Interest cost		2,432	2,441
Actuarial losses		4,008	2,132
Benefits paid		(2,140)	(1,984)
Benefit obligation at end of year	$	44,565	40,035
Change in plan assets:			
Fair value of plan assets at beginning of year		33,326	43,420
Actual return on plan assets		3,361	(8,110)
Benefits paid		(2,140)	(1,984)
Fair value of plan assets at end of year		34,547	33,326
Funded status	$	(10,018)	(6,709)
Amounts recognized in the accompanying consolidated balance sheets:			
Pension liability – other long-term liability	$	(10,018)	(6,709)

(Continued)

(Dollars in thousands)

		2010	2009
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:			
Unrecognized actuarial loss	$	13,158	10,851
Unrecognized prior service cost		2	2
Net amounts included as an accumulated charge to unrestricted net assets	$	13,160	10,853
Calculation of change in unrestricted net assets:			
Accumulated charge to unrestricted net assets, end of year	$	13,160	10,853
Reversal of accumulated credit to unrestricted net assets, prior year		(10,853)	2,357
Change in unrestricted net assets	$	2,307	13,210
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Actuarial loss arising during the year	$	2,907	13,210
Amortization of actuarial gain or loss		(600)	—
Amortization of prior service cost		—	—
Net amounts recognized as a charge to unrestricted net assets	$	2,307	13,210

(Continued)

(Dollars in thousands)

		2010	2009
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2011:			
Amortization of net loss	$	791	—
Amortization of prior service cost		—	2
Estimated future benefit payments:			
Fiscal 2011		2,211	2,150
Fiscal 2012		2,220	2,189
Fiscal 2013		2,337	2,314
Fiscal 2014		2,472	2,456
Fiscal 2015 (FY09 fiscal 2015 – 2019)		2,578	13,769
Fiscal 2016 – 2020		14,278	
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		5.50%	6.25%
Weighted average rate of increase in future compensation levels		3.00	3.00
Components of net periodic benefit cost (benefit):			
Service cost	$	230	234
Interest cost		2,432	2,441
Expected return on plan assets		(2,259)	(2,968)
Amortization of unrecognized net loss		600	—
Amortization of unrecognized prior service cost		—	0
Net periodic benefit cost (benefit)	$	1,003	(293)
Weighted average assumptions used to determine net periodic benefit cost:			
Settlement (discount) rate		6.25%	6.75%
Expected long-term return on plan assets (HVMC)		7.00	7.00
Expected long-term return on plan assets (LPH)		7.00	7.00
Weighted average rate of increase in future compensation levels		3.00	3.00

Wellmont's overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont does not expect to make any contributions to the Plans during 2011.

Wellmont has developed a plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such

(Continued)

(Dollars in thousands)

categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

The table below shows the target allocation and actual asset allocations as of June 30, 2010 and 2009:

Asset	Target allocation	June 30, 2010	June 30, 2009
Equity securities	65%	56%	53%
Fixed income	28	27	29
Cash	5% – 15%	1	3
Other	5 – 15	16	15

Wellmont monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

HVMC also participates in a health and welfare plan for its retirees. The plan provides postretirement medical and life insurance benefits to certain employees who meet minimum age and service requirements. Effective January 1, 1995, the death benefit was changed to provide a flat $5 benefit to all future retirees. During 1995, the medical program for retirees was amended to terminate medical benefits for any active employees who would not meet the full eligibility requirements of the program by January 1, 1996. The plan is contributory and contains other cost-sharing features such as deductibles and coinsurance.

(Dollars in thousands)

The following table sets forth the postretirement plan's funded status, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		2010	2009
Change in benefit obligation:			
Benefit obligation at beginning of year	$	5,653	5,637
Interest cost		320	355
Plan participants contributions		73	36
Actuarial losses		197	23
Benefits paid		(382)	(398)
Benefit obligation at end of year		5,861	5,653
Change in plan assets:			
Fair value of plan assets at beginning of year		—	—
Employer contribution		309	362
Plan participants contributions		73	36
Benefits paid		(382)	(398)
Fair value of plan assets at end of year		—	—
Funded status	$	(5,861)	(5,653)
Amounts recognized in the consolidated balance sheets consist of:			
Noncurrent liaibilities	$	(5,861)	(5,653)
Accumulated credit to unrestricted net assets		3,560	4,076
	$	(2,301)	(1,577)

Amounts recognized as an accumulated credit to unrestricted net assets consist of:

		Postretirement benefits	
		2010	2009
Net actuarial gain	$	3,560	4,076

(Continued)

(Dollars in thousands)

Net periodic benefic cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2010 and 2009 were:

	Postretirement benefits	
	2010	**2009**
Net periodic benefit cost:		
Interest cost	$ 320	355
Amortization of net gain	(319)	(335)
Net periodic benefit cost recognized	1	20
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	197	23
Amortization of net gain	319	335
Total recognized as a charge to unrestricted net assets	516	358
Total recognized in net periodic benefit cost and unrestricted net assets	$ 517	378

The net gain and prior service credit for the defined benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $(261) and $0, respectively. Weighted average assumptions used to determine benefit obligations for 2010 and 2009 were as follows:

	Postretirement benefits	
	2010	**2009**
Discount rate	5.00%	6.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2010 and 2009 were as follows:

	Postretirement benefits	
	2010	**2009**
Discount rate	6.00%	6.75%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00%	5.00%

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

(Continued)

(Dollars in thousands)

For measurement purposes, a 5% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2010.

The following table summarizes the effect of one-percentage-point increase/decrease in healthcare costs trends:

	2010	2009
Effect of one-percentage-point increase in healthcare cost trend on:		
Service and interest cost	$ 20	22
Accumulated pension benefit obligation	330	326
Effect of one-percentage-point decrease in healthcare cost trend on:		
Service and interest cost	(18)	(20)
Accumulated pension benefit obligation	(294)	(291)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2010 and 2009, respectively, were as follows:

	Fair value measurement at June 30, 2010 pension benefits – plan assets			
Asset category	**Total**	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Stock mutual funds	$ 28,803	19,412	9,391	—
Cash and money market funds	244	244	—	—
Alternative investments	5,500	—	—	5,500
Total	$ 34,547	19,656	9,391	5,500

(Continued)

(Dollars in thousands)

Asset category	Total	Fair value measurement at June 30, 2009 pension benefits – plan assets: Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Stock mutual funds	$ 27,444	17,710	9,734	—
Cash and money market funds	749	749	—	—
Alternative investments	5,133	—	—	5,133
Total	$ 33,326	18,459	9,734	5,133

The following tables presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2010 and 2009:

	Alternative investments
Balance at June 30, 2008	$ 7,960
Net change in value	(4,464)
Purchases, issuances, and settlements	1,637
Tranfers in and/or out of Level 3 (net)	—
Balance at June 30, 2009	5,133
Net change in value	254
Purchases, issuances, and settlements	113
Tranfers in and/or out of Level 3 (net)	—
Balance at June 30, 2010	$ 5,500

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers' compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont has established revocable self-insurance trust funds to provide for professional and general liability claims and workers' compensation claims and related expenses. Wellmont's contributions to the self-insurance trusts are based upon actuarial determinations by an independent service company. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Wellmont does not

(Dollars in thousands)

qualify as a self-insurer in Kentucky and hence purchases a separate policy for its operation in Kentucky. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Insurance expense under these programs amounted to approximately $3,414 and $5,658 for the years ended June 30, 2010 and 2009, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2010 and 2009, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2010 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2010 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

Wellmont is also self-insured for medical and other healthcare benefits provided to its employees and their families. A provision for estimated incurred but not reported claims has been provided in the consolidated financial statements.

(15) Commitments and Contingencies

Construction in progress at June 30, 2010 and 2009 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately $11,920 at June 30, 2010. Wellmont has entered into contracts of approximately $11,920 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was $16,857 and 16,441 for the years ended June 30, 2010 and 2009, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2010 are as follows:

2011	$	14,227
2012		12,318
2013		8,149
2014		3,763
2015		3,383
Thereafter		20,699
	$	62,539

The HCHM lease to WHCMH is for 20 years and can be automatically extended for two additional terms of 10 years each. Should WHCMH generate annual net excess revenue over expenses, 50% shall be transferred to a designated fund in the Foundation for the purpose of healthcare projects. No transfers were required for the years ended June 30, 2010 and 2009.

(Dollars in thousands)

Wellmont has entered into contractual employment relationships with physicians to provide services to Wellmont physician practices that are intended to qualify under the employee safe harbor of the Anti-Kickback Statute and the employee exception of the Physician Self-Referral Law. These contracts have terms of varying lengths, guarantee certain base payments, and may provide for additional incentives based upon productivity.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, such matters as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes Wellmont is in compliance with fraud and abuse statutes and other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

(16) Functional Expense Disclosure

Wellmont provides healthcare services to residents within its geographic location. Expenses based upon functional classification related to providing these services during the years ended June 30 are as follows:

		2010	2009
Professional care of patients	$	583,222	597,951
Administrative and general		117,123	101,641
Fund-raising		1,235	1,260
	$	701,580	700,852

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately $52,000 at June 30, 2010, which begin expiring in fiscal 2016 and expire through 2030. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately $975 for unrelated business activities. Management believes that it is not more likely than not that deferred tax assets arising from net operating loss carryforwards will be realizable. Accordingly, these are fully reserved at June 30, 2010 and 2009.

(Continued)

(Dollars in thousands)

(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2010 and 2009 was as follows:

	2010	2009
Medicare	46%	45%
TennCare	4	4
Medicaid	8	8
Other third-party payors	31	31
Patients	11	12
	100%	100%

(19) Disclosures about Fair Value of Financial Instruments

(a) Fair Value of Financial Instruments

The following methods and assumptions were used to estimate fair value of each class of instruments:

Cash and Cash Equivalents

The carrying amount approximates fair value due to the short maturities of these instruments.

Patient Accounts and Other Receivables

The net recorded carrying value approximates fair value due to the short maturities of these instruments.

Investments and Assets Limited as to Use

The fair values of investments and assets limited as to use are based on quoted market prices and quotes obtained from security brokers or, in the case of the limited partnerships, by the general partner.

Accounts Payable and Accrued Expenses

The carrying amount approximates fair value due to the short maturities of these liabilities.

Estimated Third-Party Payor Settlements, Other Long-Term Liabilities

The carrying amount approximates fair market value due to the nature of these liabilities.

Long-Term Debt

The fair value of revenue bonds, using current market rates, was estimated at $422,290 and $344,863 for the years ended June 30, 2010 and 2009, respectively.

(b) Fair Value Hierarchy

On July 1, 2008, Wellmont adopted new guidance issued by FASB for fair value measurement of financial assets and financial liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis now codified into ASC 820, *Fair Value Measurements and Disclosures*. ASC 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date.

- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

In conjunction with the adoption of the new guidance, Wellmont elected to early adopt the measurement provisions of Accounting Standards Update No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was $56,972 and $37,312 at June 30, 2010 and 2009, respectively.

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2010:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 35,711	—	—	35,711
Assets limited as to use:				
Stock mutual funds	109,629	—	—	109,629
Bond mutual funds	71,698	—	—	71,698
Cash and money market funds	50,555	—	—	50,555
Real estate funds	7,468	—	—	7,468
Alternative investments		18,043	39,362	57,405
Corporate bonds	6,867	—	—	6,867
	246,217	18,043	39,362	303,622
Long-term investments:				
Stock mutual funds	9,279	—	—	9,279
Bond mutual funds	7,599	—	—	7,599
Cash and money market funds	287	—	—	287
Real estate funds	1,722	—	—	1,722
Alternative investments	—	1,992	—	1,992
	18,887	1,992	—	20,879
Total assets	$ 300,815	20,035	39,362	360,212
Liabilities:				
Interest rate derivatives liability	$ —	12,943	—	12,943
Total liability	$ —	12,943	—	12,943

(Continued)

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2009:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 60,889	—	—	60,889
Assets limited as to use:				
Stock mutual funds	108,036	—	—	108,036
Bond mutual funds	5,910	—	—	5,910
Cash and money market funds	85,386	—	—	85,386
Real estate funds	5,419	—	—	5,419
Alternative investments		2,295	33,291	35,586
Corporate bonds	7,464	—	—	7,464
	212,215	2,295	33,291	247,801
Long-term investments:				
Stock mutual funds	8,631	—	—	8,631
Bond mutual funds	3,648	—	—	3,648
Cash and money market funds	5,202	—	—	5,202
Real estate funds	1,255	—	—	1,255
Alternative investments	—	1,726	—	1,726
	18,736	1,726	—	20,462
Total assets	$ 291,840	4,021	33,291	329,152
Liabilities:				
Interest rate derivatives liability	$ —	10,250	—	10,250
Total liability	$ —	10,250	—	10,250

(Continued)

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2010 and 2009:

		Alternative investments
Balance at June 30, 2008:	$	51,661
Total realized and unrealized gains (losses):		
Included in revenues and gains in excess of expenses and losses		—
Included in changes in net assets		(3,574)
Purchases, issuances, and settlements		(14,796)
Transfers in and/or out of Level 3 (net)		—
Balance at June 30, 2009:	$	33,291
Total realized and unrealized gains (losses):		
Included in revenues and gains in excess of expenses and losses		—
Included in changes in net assets		469
Purchases, issuances, and settlements		5,602
Transfers in and/or out of Level 3 (net)		—
Balance at June 30, 2010	$	39,362

APPENDIX C.

SUMMARY OF THE FINANCING DOCUMENTS

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SUMMARY OF THE FINANCING DOCUMENTS

Brief descriptions of the Master Indenture, the 2011 Bond Indenture and the Loan Agreement are included hereafter 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 2011 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 Corporation and the Bond Trustee. All references to the Series 2011 Bonds are qualified in their entirety by reference to the definitive forms thereof and the information with respect thereto included in the 2011 Bond Indenture.

DEFINITIONS OF CERTAIN TERMS

The following are definitions of certain terms used in the Master Indenture, the 2011 Bond Indenture, the Loan Agreement and the Official Statement. Certain definitions used below may have been modified so long as the Series 2011 Obligation is outstanding. See "Summary of Certain Provisions of the Master Indenture - Provisions Applicable as Long as Series 2011 Obligation Outstanding."

"Accountant" means any Person who or which is appointed (a) by any member of the Combined Group for the purpose of examining and reporting on or passing on questions relating to the financial statements of such member or (b) by the Obligated Group Agent for the purpose of examining and reporting on or passing on questions relating to the financial statements of two or more members of the Combined Group or the entire Combined Group, has all certifications necessary for the performance of such services, and, in the good faith opinion of the person making the appointment, has a favorable reputation for skill and experience in performing similar services in respect of entities of a comparable size and nature. If any Accountant's report or opinion is required to be given with respect to matters partly within and partly without the expertise of such Accountant, such Accountant may rely upon the report or opinion of another Accountant, which other Accountant shall be reasonably satisfactory to the relying Accountant and the Obligated Group Agent.

"Act" means Sections 48-101-301 to 48-101-318, Tennessee Code Annotated, as from time to time amended.

"Act of Bankruptcy" means the filing of a petition in bankruptcy (or any other commencement of a bankruptcy or similar proceeding) by or against the Corporation or any affiliate of the Corporation under any applicable bankruptcy, insolvency, reorganization or similar law, now or hereafter in effect.

"Additional Indebtedness" means any Indebtedness (including all Obligations, other than the Series 2003 Obligation, the Series 2005 Obligations, the Series 2006C Obligation, the Series 2007A Obligation, the Series 2010 Obligation, the Series 2011 Obligation and Series 2011 Swap Obligation) incurred by any Obligated Issuer, subsequent to its becoming an Obligated Issuer.

"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.

"Architect" means a Person who or which is appointed by any member of the Combined Group for the purpose of passing on questions relating to the design and construction of Facilities, has all licenses and certifications necessary for the performance of such services, and, in the good faith opinion of the Person making the appointment, has a favorable reputation for skill and experience in performing similar service in respect of Facilities of a comparable size and nature.

"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.

"Bankruptcy Law" means the United States Bankruptcy Code, 11 U.S.C. §§ 101 et seq. or any similar statute.

"Bond Counsel" means a firm of nationally recognized standing in the field of municipal finance law whose opinions are generally accepted by purchasers of public obligations and who is acceptable to the Bond Trustee.

"Bond Fund" means the fund by that name created pursuant to the provisions of the 2011 Bond Indenture.

"Bond Index" means (i) in respect of any Outstanding Indebtedness, the average interest rate on such Indebtedness for the twelve (12) months immediately preceding the month prior to such calculation, or if such Indebtedness shall have had a variable rate for less than a twelve (12) month period, the average interest rate on such Indebtedness for such lesser period; and (ii) in respect of any proposed Indebtedness, at the option of the Obligated Group Agent, the initial rate established or reasonably expected to be established for such Indebtedness, as determined by an Officer's Certificate.

"Bond Trustee" means The Bank of New York Mellon Trust Company, N.A., a national banking association organized and existing under the laws of the United States, and its successors and any corporation resulting from or surviving any consolidation or merger to which it or its successors may be a party and any successor Bond Trustee at the time serving as successor Bond Trustee under the 2011 Bond Indenture.

"Book Entry System" means the system maintained by the Securities Depository as provided in the 2011 Bond Indenture.

"Book Value", when used in connection with Property of any member of the Combined 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 Combined Group, means the aggregate of the values so determined with respect to such Property of all members of the Combined Group determined in such a manner that no portion of such value of Property of any member of the Combined Group is included more than once.

"Business Day" means any day other than (a) a Saturday or Sunday, (b) a day on which the Bond Trustee is required or permitted by law to close, and (c) a day on which the New York Stock Exchange is closed.

"Capitalization" means the principal amount of all outstanding Long-Term Indebtedness of the Combined Group, plus the equity accounts of the Combined Group (i.e., unrestricted fund balances, including any shareholder equity or partnership equity).

"Code" means the Internal Revenue Code of 1986, as amended from time to time, and any successor thereto.

"Combined Group" means the Obligated Group and all Restricted Affiliates.

"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 (a) 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 of the Master Indenture, and (b) with a principal amount

not in excess of the amount required (1) to provide a completed and equipped Facility of substantially the type and scope contemplated at the time such prior Long-Term Indebtedness was incurred, (2) to provide for capitalized interest during the period of construction, (3) to capitalize a reserve with respect to such Completion Indebtedness and (4) 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.

"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 Combined Group or the entire Combined 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.

"Corporation" means Wellmont Health System, a Tennessee nonprofit corporation, and its successors and assigns and any surviving, resulting or transferee entity as provided in the Agreement.

"Corporation Representative" means the person or persons at the time designated to act on behalf of the Corporation by written certificate furnished to the Issuer and the Bond Trustee containing the specimen signatures of such person or persons and signed on behalf of the Corporation by its President or Vice President. Such certificate may designate an alternate or alternates.

"Costs of Issuance" means the fees, costs, expenses and other charges incurred in connection with the issuance of the Series 2011 Bonds, including, but not limited to, the following: (a) counsel fees (including but not limited to Bond Counsel, Issuer's counsel, Trustee's counsel, Corporation's counsel, and underwriter's counsel); (b) underwriter's discount and financial advisor fees incurred in connection with the issuance of the Series 2011 Bonds; (c) initial Trustee acceptance and set-up fees and expenses incurred in connection with the issuance of the Series 2011 Bonds; (d) Trustee and authenticating agent fees and expenses related to issuance of the Series 2011 Bonds; and (e) printing costs for any offering materials.

"Costs of Issuance Fund" means the fund by that name created pursuant to the provisions of the 2011 Bond Indenture.

"Counsel" means a lawyer duly admitted to practice law before the highest court of any state in the United States of America or the District of Columbia, or any law firm, who or which, as the case may be, is not unsatisfactory to any recipient of the opinion to be rendered by such Counsel.

"Cross Guarantee" means the obligations of each Obligated Issuer pursuant to Section 2.3 of the Master Indenture.

"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) (a) that any Indebtedness represented by a Guaranty shall be deemed payable on the dates and in the amounts contemplated in Section 4.3 of the Master Indenture (concerning the assumptions to be used in including debt service requirements of the guaranteed obligations), (b) 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 of the Master Indenture, (c) 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, and (d) 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), or funded from the proceeds of such Long-Term Indebtedness (i.e., accrued and capitalized interest), shall be excluded from the determination of the Debt Service Requirement.

"Eighth Supplemental Master Indenture" means the Eighth Supplemental Master Indenture, dated as of November 1, 2006, among the Corporation (as successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2006C Obligation was issued.

"Eleventh Supplemental Master Indenture" means the Eleventh Supplemental Master Indenture dated as of May 1, 2011 among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2011 Obligation is issued.

"Escrow Deposit" means a segregated escrow fund or other similar fund, account or deposit in trust of cash in an amount (or Investment Securities 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.

"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:

(a) 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

(b) 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

(c) $1.00.

"Fifth Supplemental Master Indenture" means the Fifth Supplemental Master Indenture, dated as of February 1, 2003, among the Corporation (as successor to Bristol Memorial Hospital) as a member of the Obligated Group, Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2003 Obligation was issued.

"Financial Advisor" means an investment banking or financial advisory firm, commercial bank or any other qualified Person who or which is appointed by the Obligated Group Agent for the purpose of passing on questions relating to the availability and terms of specified types of Indebtedness for any member of the Combined Group and is actively engaged in and, in the good faith opinion of the Obligated Group Agent, has a favorable reputation for skill and experience in underwriting or providing financial advisory services in respect of similar types of Indebtedness incurred by entities engaged in reasonably comparable endeavors.

"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 their assigns, and, if such corporation is dissolved or liquidated or no longer performs the functions of a securities rating agency, "Fitch" will be deemed to refer to any other nationally recognized securities rating agency designated by the Corporation by written notice to the Bond Trustee.

"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" as used in the Master Indenture means (i) 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 custody agreement, and (ii) obligations issued by any state of the United States of America or any political subdivision, public instrumentality or public authority of any state of the United States of America, provision for the full and timely payment of the principal or premium of and interest on which shall have been made by deposit with a trustee or escrow agent, pursuant to an irrevocable security agreement, of obligations described in clause (i) above.

"Government Obligations" as used in the 2011 Bond Indenture means direct general obligation of, or obligations the payment of the principal of and interest on which are unconditionally guaranteed as to full and timely payment by, the United States of America, which obligations are noncallable.

"Gross Receipts" means all receipts, revenues, income, gifts, donations, contributions, grants, bequests, pledges, chattel paper and instruments and other moneys received by or on behalf of the Obligated Group, including, but without limiting the generality of the foregoing, (a) revenues derived from the ownership or operation of Property, including insurance and condemnation proceeds with respect to Property or any portion thereof, and (b) all rights to receive the same, whether in the form of accounts, accounts receivable, contract rights or other rights and the proceeds of such rights, whether now owned, or held or hereafter coming into existence; provided however that (i) gifts, donations, contributions, grants (including Hill-Burton grants), bequests and pledges heretofore or hereafter made and designated as specified by the granting authority, donor or maker thereof as being for specified purposes (inconsistent with the payment of debt service on Indebtedness) and income derived therefrom to the extent required by such designation or specification, and (ii) revenues, receipts and income derived from the ownership and operation of Property which secures Non-Recourse Indebtedness shall be excluded from Gross Receipts.

"Guaranty" means any obligation of a Combined Group member guaranteeing any obligation of any other Person other than a Combined 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 Combined Group, constitute Indebtedness thereunder.

"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 Combined 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 Combined 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 Combined 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

depository 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 means 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 depository 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.

"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 after tax, as determined in accordance with generally accepted accounting principles, to which shall be added, in either case, (a) depreciation, (b) amortization, and (c) interest expense on Indebtedness, and from which shall be excluded any extraordinary items, 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 and any revenues or expenses of any Person which is not a member of the Combined Group.

"Indebtedness" of a Person means (a) all Notes and Guaranties, (b) all liabilities (exclusive of reserves) recorded as indebtedness 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 (c) all other obligations for borrowed money; provided that Indebtedness shall not include (1) Subordinated Indebtedness, (2) Interest Rate Swap Obligations, (3) any other Indebtedness of any member of the Combined Group to any other member of the Combined Group, (4) rentals payable under leases which are not properly capitalized under generally accepted accounting principles, or (5) any other obligation which does not constitute indebtedness under generally accepted accounting principles.

"Indenture Guaranty" means any Guaranty issued under the Master Indenture by an Obligated Issuer.

"Insurance Consultant" means a Person, who or which is appointed by any member of the Combined Group for the purpose of reviewing and recommending insurance coverage for the Facilities and operations of one or more members of the Combined Group or the entire Combined Group and, in the good faith opinion of the person making the appointment, has a favorable reputation for skill and experience in performing such services in respect of Facilities and operations of a comparable size and nature. If an Insurance Consultant's report or opinion is required to be given with respect to matters partly within and partly without the expertise of such Insurance Consultant, such Insurance Consultant may rely upon the report or opinion of another Insurance Consultant or other expert, which other Insurance Consultant or other expert shall be reasonably satisfactory to the relying Insurance Consultant and the Obligated Group Agent.

"Interest Payment Date" means each March 1 and September 1, commencing September 1, 2011.

"Investment Securities" means and includes the following:

(a) Government Obligations;

(b) debt obligations issued by any of the following agencies or such other like governmental or government-sponsored agencies which may be hereafter created; Bank for Cooperatives; Federal Intermediate Credit Banks; Federal Financing Bank; Federal Home Loan Bank System; Federal National Mortgage Association; Export-Import Bank of the United States; Farmers Home Administration; Small Business Administration; Inter-American Development Bank; International Bank for Reconstruction and Development; Federal Land Banks; Government National Mortgage Association; or Resolution Funding Corporation;

(c) long-term debt obligations of any state or political subdivision thereof or any agency or instrumentality of such a state or political subdivision or of any corporation, provided that such obligations are rated by S&P or Moody's in any of the three highest rating categories (without reference to sub-categories) assigned by S&P or Moody's;

(d) rights to receive the principal of or the interest on obligations of states, political subdivisions, agencies or instrumentalities meeting the requirements set forth in subparagraph (c) above, whether through

(1) direct ownership as evidenced by physical possession of such obligations or unmatured interest coupons or by registration as to ownership on the books of the issuer or its duly authorized paying agent or transfer agent, or

(2) purchase of certificates or other instruments evidencing an undivided ownership interest in payments of the principal of or interest on such obligations;

(e) negotiable and non-negotiable certificates of deposit, time deposits or other similar banking arrangements which are issued by banks, trust companies or savings and loan associations, provided that, unless issued by a Qualified Financial Corporation, any such certificate, deposit or other arrangement shall be continuously secured as to principal in the manner and to the extent provided in the last paragraph of this definition;

(f) repurchase agreements for Investment Securities described in subparagraph (a) or (b) above with a Qualified Financial Corporation or with dealers in government bonds which report to, trade with and are recognized as primary dealers by a Federal Reserve Bank or are members of the Securities Investors Protection Corporation, provided that the repurchase price payable under any such agreement shall be continuously secured in the manner and to the extent provided in the last paragraph of this definition;

(g) investment agreements with Qualified Financial Corporations;

(h) commercial paper rated in the highest rating category (without reference to sub-categories) by S&P or Moody's;

(i) shares or certificates in any short-term investment fund which short-term investment fund invests solely in obligations described in subparagraph (a), (b), (c) or (h) above; or

(j) debt obligations of any foreign government or political subdivision thereof or any agency or instrumentality of such foreign government or political subdivision provided that such obligations are rated by S&P or Moody's (without reference to subcategories) in the highest rating category assigned by S&P or Moody's.

Any security required to be maintained for Investment Securities in the form of certificates of deposit, time deposits, other similar banking arrangements and repurchase agreements described in subparagraphs (e) and (f) above shall be subject to the following:

(1) the collateral shall be in the form of obligations described in subparagraphs (a) or (b) above, except that the security for certificates of deposit, time deposits or other similar banking arrangements may include other marketable securities which are eligible as security for trust funds under applicable regulations of the Comptroller of the Currency of the United States of America or under applicable state laws and regulations.

(2) the collateral shall have an aggregate market value, calculated not less frequently than monthly, at least equal to the principal amount (less any portion insured by the Federal Deposit Insurance Corporation or any comparable insurance corporation chartered by the United States of America) or the repurchase price secured thereby, as the case may be. The instruments governing the issuance of and security for the Investment Securities shall designate the Person responsible for making the foregoing calculations; provided that the Master Trustee shall make such calculations if they are not made by the Person so designated.

"Issuer" means The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee.

"Lien" means any mortgage or pledge of, security interest in or lien or encumbrance on any Property of any member of the Combined Group in favor of, or which secures any Indebtedness or any other obligation of any member of the Combined Group to any Person other than another member of the Combined Group, but specifically excluding subordination arrangements among creditors.

"Limited Obligor" means any Person, other than a member of the Combined Group, on whose account any Obligated Issuer has issued a Guaranty as consideration for such Person's execution and delivery to such Obligated Issuer of a Pledged Note.

"Long-Term Indebtedness" means (a) 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 (b) 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 Section 4.2 of 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 Section 4.2 of the Master Indenture; provided, that, Long-Term Indebtedness shall not include (1) Non-Recourse Indebtedness or Subordinated Indebtedness; (2) current obligations payable out of current revenues, including current payments for the funding of pension plans and contributions to self insurance programs; (3) 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 (4) rentals payable under leases which are not properly capitalized under generally accepted accounting principles.

"Master Indenture" means the Master Trust Indenture, dated as of May 1, 1991, between the Corporation's predecessor, Bristol Memorial Hospital, and the Master Trustee, as supplemented prior to the date hereof, and as further supplemented by the Eleventh Supplemental Master Indenture and Twelfth Supplemental Master Indenture and as it may from time to time be amended or supplemented in accordance with the terms thereof.

"Master Trustee" means U.S. Bank National Association (as successor to Wachovia Bank, National Association, First Union National Bank and Dominion Bank of Middle Tennessee), or any successor master trustee under the Master Indenture.

"Maximum Annual Debt Service" of the Combined Group means the highest annual Debt Service Requirement of the Combined 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 (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 in part, with the proceeds of such Obligations by such Person.

(ii) The greatest of the Fair Value Net Worth of such Person as of the latest fiscal year-end of such Person, each fiscal year-end of such Person thereafter occurring on or prior to the date of the determination of Maximum Guaranty Liability, the date on which enforcement of the pertinent Cross Guarantee is sought, and the date on which a case under the U.S. Bankruptcy Code is commenced with respect to any Obligated Issuer.

"Moody's" means Moody's Investors Service, Inc., a corporation organized and existing under the laws of the State of Delaware, its successors and assigns, and, if such corporation is dissolved or liquidated or no longer performs the functions of a securities rating agency, "Moody's" will be deemed to refer to any other nationally recognized securities rating agency designated by the Corporation by written notice to the Bond Trustee.

"Net Operating Revenues" of a Person means, with respect to any period of time, operating revenues less contractual allowances, free care, discounts and allowances for bad debts, all determined in accordance with generally accepted accounting principles.

"Ninth Supplemental Master Indenture" means the Ninth Supplemental Master Indenture dated as of July 1, 2007 among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee, pursuant to which the Series 2007A Obligation is issued.

"Non-Arbitrage Certificate" means the Non-Arbitrage Certificate dated the date of delivery of the Series 2011 Bonds and executed by the Issuer.

"Non-Recourse Indebtedness" means any Indebtedness secured by a Lien on any real property, fixtures and tangible personal property, which Indebtedness is not a general obligation of the Obligated Group or any Obligated Issuer, and the liability for which Indebtedness is effectively limited to the property subject to such Lien (and the revenues derived therefrom), with no recourse, directly or indirectly, to any other property.

"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 thereof.

"Obligated Group" means the Corporation, Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and each other Person who becomes a member of the Obligated Group in accordance with the Master Indenture.

"Obligated Group Agent" means the Corporation and any successor Obligated Group Agent appointed pursuant to the Master Indenture.

"Obligated Issuer" means (a) the Corporation, Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc. and Wellmont Foundation and each other Person which becomes an Obligated Issuer in accordance with the provisions of Article Three 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 Article Three thereof, and (b) 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 under the Master Indenture and any additional forms of Obligations created pursuant to Section 9.1 of 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 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.

"Outstanding" (a) when used with reference to Notes, means, as of any date of determination, all Notes theretofore issued or incurred and not paid and discharged other than (1) Notes theretofore cancelled by the Master Trustee or delivered to the Master Trustee for cancellation, (2) Notes deemed paid and no longer Outstanding as provided in Article XI of the Master Indenture or for which an Escrow Deposit has been established, (3) Notes in lieu of which other Notes have been authenticated and delivered or have been paid pursuant to the provisions of the Master Indenture regarding mutilated, destroyed, lost or stolen Notes unless proof satisfactory to the Master Trustee has been received that any such Note is held by a bona fide purchaser for value without notice, and (4) any Note held by any Obligated Issuer; or, (b) all Indenture Guaranties unless the Master Trustee has received from the Holder thereof a written release of all claims thereof against the Obligated Issuer thereunder and all other Obligated Issuers; or, (c) when referring to Indebtedness other than Notes and Indenture Guaranties, means, as of any date of determination, all Indebtedness theretofore issued or incurred other than (1) Indebtedness which has been paid, (2) Indebtedness for which an opinion of Counsel stating that such Indebtedness has been discharged has been provided to the Master Trustee, (3) evidence of Indebtedness for which new evidence has been substituted in a manner analogous to clause (a)(3) above, and (4) any evidence of Indebtedness held by any Obligated Issuer, provided that Obligations or evidences of Indebtedness held by any Obligated Issuer may be deemed by such Obligated Issuer to be continuously Outstanding if such Obligations or evidences of Indebtedness were acquired with an intent that they only be held temporarily in connection with an effort to remarket them to Persons other than the Obligated Issuer.

"Outstanding" or "Bonds Outstanding" means all Series 2011 Bonds which have been authenticated and delivered by the Bond Trustee under the 2011 Bond Indenture, except:

(a) Series 2011 Bonds canceled after purchase in the open market or because of payment at, or redemption prior to, maturity;

(b) Series 2011 Bonds paid or deemed paid pursuant to the 2011 Bond Indenture;

(c) Series 2011 Bonds in lieu of which others have been authenticated under the provisions of the 2011 Bond Indenture; and

(d) Series 2011 Bonds deemed tendered under the 2011 Bond Indenture and for which another Series 2011 Bond has been issued.

"Owner" means the person or persons in whose name or names a Series 2011 Bond is registered on the books of the Issuer kept by the Bond Trustee for that purpose in accordance with provisions of the 2011 Bond Indenture.

"Participant" means one of the entities which is a member of the Securities Depository and deposits securities, directly or indirectly, in the Book Entry System.

"Permitted Liens" means the Master Indenture, all Related Financing Documents and, as of any particular time:

(a) Any judgment lien or notice of pending action against any member of the Combined 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 the Master Indenture nor any Property of any member of the Combined Group will be materially impaired or subject to material loss or forfeiture;

(b) (1) 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 (i) 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 (ii) purchase, condemn, appropriate or recapture, or designate a purchaser of, such Property; (2) 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; (3) 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; (4) 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 (5) to the extent that it affects title to any Property, the Master Indenture;

(c) Any lease which relates to Property of the Combined 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;

(d) 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;

(e) 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 Combined 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;

(f) 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 Combined 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;

(g) Any Lien arising by reason of an Escrow Deposit;

(h) (1) 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 (2) Liens in favor of a trustee, including the Master Trustee, to secure obligations to compensate, reimburse or indemnify such trustees;

(i) Any Lien on moneys deposited by patients or others with any member of the Combined Group as security for or as prepayment for the cost of patient care;

(j) Any Lien on Property received by any member of the Combined Group through gifts, grants or bequests, such Lien being due to restrictions on such gifts, grants or bequests of property or the income thereon;

(k) 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;

(l) Liens existing at the time of a Consolidation or Merger pursuant to Section 6.4 of the Master Indenture, on the date of acquisition of any Property or at the time a Person becomes an Obligated

Issuer pursuant to "-Persons Becoming Obligated Issuers" below or a Restricted Affiliate pursuant to "-Conditions for Designation of Restricted Affiliates" below;

(m) Liens existing at the time of any consolidation, merger, sale or conveyance pursuant to Section 6.4 of the Master Indenture, on the date of acquisition of any Property or at the time a Person becomes an Obligated Issuer pursuant to "-Persons Becoming Obligated Issuers" below or a Restricted Affiliate pursuant to "-Conditions for Designation of Restricted Affiliates" below; provided that

(1) No lien so described may be extended or renewed, nor may it be modified, to apply to any Property or any member of the Obligated Group not subject to such lien on the effective date, unless the lien as so extended, renewed or modified, or the replacement lien, otherwise qualified as a Permitted Encumbrance;

(2) No Additional Indebtedness may be thereafter incurred that is secured by such lien;

(3) No such lien was created in order to avoid the limitations contained herein on the imposition of liens on the property of the Obligated Group; and

(4) Such indebtedness does not become part of the Indebtedness of the Obligated Group.

(n) Any Lien described in Exhibit A to the Master Indenture which is existing on the date of authentication and delivery of the Initial Obligation 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 Combined Group not subject to such Lien on such date, unless such Lien as so extended, renewed or modified otherwise qualifies as a Permitted Lien thereunder;

(o) A security interest in any funds or accounts established pursuant to the provisions of any Related Financing Documents;

(p) Liens in the form of purchase money security interests in Property financed with the proceeds of Indebtedness secured thereby;

(q) Deposits of cash or cash equivalents to secure obligations under letters of credit incurred in the ordinary course of business of any member of the Combined Group.

"Person" means an individual, a corporation, a partnership, an association, a joint stock company, a joint venture, a trust, an unincorporated organization, a governmental unit or an agency, political subdivision or instrumentality thereof or any other group or organization of individuals.

"Pledged Note" means a promissory note executed by a Limited Obligor, as maker, in favor of an Obligated Issuer, as payee, evidencing a sum certain liability of such maker to such payee, which is assigned by such payee to the Master Trustee pursuant to Section 2.3 of the Master Indenture.

"Principal Office" of the Bond Trustee means the address specified in the 2011 Bond Indenture or such other address as may be designated in writing to the Issuer and the Corporation.

"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 Combined Group.

"Property" means any and all land, leasehold interests, building, machinery, equipment, hardware, and inventory of each Obligated Issuer wherever located and whether now or hereafter acquired, and any and all rights,

title and interest in and to any and all property whether real or personal, tangible or intangible and wherever situated and whether now or hereafter acquired.

"Property, Plant and Equipment" means all Property which is classified as property, plant and equipment under generally accepted accounting principles.

"Qualified Financial Corporation" means a bank, trust company, national banking association, insurance company or other financial services company whose unsecured long-term debt obligations (in the case of a bank, trust company, national banking association or other financial services company) or whose claims paying abilities (in the case of an insurance company) are rated in any of the three highest rating categories (without reference to sub-categories) by S&P or Moody's. For purposes hereof, the term "financial services company" shall include any investment banking firm or any affiliate or division thereof which may be legally authorized to enter into the transactions described in the Master Indenture pertaining, applicable or limited to a Qualified Financial Corporation.

"Rating Agency" means, severally or collectively, if applicable (a) S&P 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, (b) Moody's 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 (c) Fitch 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, the 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.

"Rebate Fund" means the fund by that name created pursuant to the provisions of the 2011 Bond Indenture.

"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, means 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, (1) 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 the Master Indenture) is granted, and (2) 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.

"Reserved Rights" means amounts payable to the Issuer pursuant to the Loan Agreement as described under "Summary of Certain Provisions of the Loan Agreement - Obligation Payments; Fund Deposits; Prepayments and Other Payments - Additional Payments," "- Particular Covenants of the Corporation - Indemnity" and "- Defaults and Remedies - Agreement to Pay Attorneys' Fees, Costs and Expenses" below, and the right of the Issuer to receive notices.

"Responsible Officer" when used with respect to the Bond Trustee, means any officer within the corporate trust administrative department of the Bond Trustee, including any vice president, any assistant vice president, any trust officer, or any other officer of the Bond Trustee customarily performing functions similar to those performed by any of the above designated officers and also means, with respect to a particular corporate trust matter, any other officer to whom such matter is referred because of his or her knowledge of and familiarity with the particular subject.

"Restricted Affiliate" means any Affiliate of a member of the Obligated Group that:

(a) is either (1) a non-stock membership corporation of which one or more members of the Combined Group are the sole members, or (2) a non-stock, non-membership corporation or a trust of which the sole beneficiaries or controlling Persons are one or more members of the Combined Group, or (3) a stock corporation all of the outstanding shares of stock of which are owned by one or more members of the Combined Group, and

(b) if such Affiliate is a non-stock corporation or a trust,

(1) has the legal power, with approval of a majority of its Governing Body but without the consent of any other Person, to transfer to any Obligated Issuer (or to another Restricted Affiliate that possesses the power to transfer to any Obligated Issuer) money required for the payment of Indebtedness of any Obligated Issuer, and

(2) one or more members of the Combined Group have the sole right to elect or appoint and to remove, with or without cause, a majority of the members of the Governing Body thereof, and

(3) has the ability under applicable law and its organizational documents, with approval of a majority of the members of its Governing Body, to transfer all assets of such Affiliate remaining after payment of its debts to any Obligated Issuer or to another Restricted Affiliate whose remaining assets may be so transferred, provided that if such Affiliate is an organization described in Section 501(c)(3) of the Code, then for so long as the applicable Obligated Issuer is an organization described in Section 501(c)(3) of the Code, the organizational documents of such Affiliate and applicable law may (i) provide for the naming of another member of the Combined Group as a substitute beneficiary if the then current beneficiary ceases to be an organization described in Section 501(c)(3) of the Code and (ii) prohibit transfers to organizations not described in Section 501(c)(3) of the Code, and

(c) has satisfied (or a predecessor has satisfied) the requirements set forth in the Master Indenture for becoming a Restricted Affiliate and has not thereafter ceased to satisfy the requirements of clauses (a) and (b) above or satisfied the requirements set forth in the Master Indenture for ceasing to be a Restricted Affiliate.

The fact that one or more specified elements described above is not satisfied shall not disqualify a Person as a Restricted Affiliate if, in the written opinion of Counsel to such Restricted Affiliate delivered to the Master Trustee, substantially all of the indicia described above relating to the power to transfer Property of, and control, the

applicable Affiliate of a member of the Combined Group, is vested in one or more members of the Combined Group.

"Securities Depository" means The Depository Trust Corporation, New York, New York, or its nominee, and its successors and assigns.

"Series 2003 Bonds" means the Issuer's Hospital Revenue Refunding Bonds (Wellmont Health System Project) Series 2003 issued in the original aggregate principal amount of $59,100,000 pursuant to the terms and conditions of the Bond Trust Indenture dated as of February 1, 2003 between the Issuer and BNY Trust Company of Missouri, as bond trustee thereunder.

"Series 2003 Obligation" means the $59,100,000 principal amount Wellmont Health System Note (The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Refunding Series 2003, issued pursuant to the Fifth Supplemental Master Indenture

"Series 2005 Bonds" means the Issuer's Hospital Revenue Refunding Bonds (Wellmont Health System Project) Series 2005 issued in the original aggregate principal amount of $70,620,000 pursuant to the terms and conditions of the Bond Trust Indenture dated as of December 1, 2005 between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee thereunder.

"Series 2005 Obligations" means the $70,620,000 principal amount Wellmont Health System Note (The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Refunding Series 2005, and the $71,548,702 principal amount Standby Note (2005 Master Note) of the Obligated Group, Reimbursement Obligation, each issued pursuant to the Sixth Supplemental Master Indenture.

"Series 2006C Bonds" means the Issuer's Hospital Revenue Bonds (Wellmont Health System Project) Series 2006C issued in the original aggregate principal amount of $200,000,000 pursuant to the terms and conditions of the Bond Trust Indenture dated as of November 1, 2006 between the Issuer and The Bank of New York Mellon Trust Company, N.A., as bond trustee thereunder.

"Series 2006C Obligation" means the $200,000,000 principal amount Wellmont Health System Note (The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Series 2006C, issued pursuant to the Eighth Supplemental Master Indenture.

"Series 2007A Bonds" means the Virginia Small Business Financing Authority's Hospital Revenue Bonds (Wellmont Health System Project), Series 2007A issued in the original aggregate principal amount of $55,000,000 pursuant to the terms and conditions of the Bond Trust Indenture dated as of July 1, 2007 between the Virginia Small Business Financing Authority and The Bank of New York Mellon Trust Company, N.A., as bond trustee thereunder.

"Series 2007A Obligation" means the $55,000,000 principal amount Wellmont Health System Note (Virginia Small Business Financing Authority), Series 2007A, issued pursuant to the Ninth Supplemental Master Indenture.

"Series 2010 Bond" means the Issuer's Hospital Revenue Bond (Wellmont Health System Project), Series 2010 (Bank Qualified) issued in the original aggregate principal amount of $30,000,000 pursuant to the terms and conditions of the Bond Purchase Agreement dated as of November 1, 2010 between the Issuer and First Tennessee Bank National Association, a national banking association, as purchaser.

"Series 2010 Obligation" means the $30,000,000 principal amount Wellmont Health System Note (The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Series 2010, issued pursuant to the Tenth Supplemental Master Indenture.

"Series 2011 Bonds" means the Issuer's Hospital Revenue Refunding Bonds (Wellmont Health System Project), Series 2011 issued in the original aggregate principal amount of $76,165,000 pursuant to the terms and

conditions of the Bond Trust Indenture dated as of May 1, 2011 between The Bank of New York Mellon Trust Company, N.A., as bond trustee thereunder.

"Series 2011 Obligation" means the $76,165,000 principal amount Wellmont Health System Note (The Health Educational and Housing Facilities Board of the County of Sullivan, Tennessee), Series 2011, issued pursuant to the Eleventh Supplemental Master Indenture.

"Series 2011 Swap Obligation" means the Wellmont Health System Promissory Note Constituting Series 2011 Swap Obligation, issued pursuant to the Twelfth Supplemental Master Indenture.

"Short-Term Indebtedness" means all Indebtedness other than Long-Term Indebtedness.

"Sixth Supplemental Master Indenture" means the Sixth Supplemental Master Indenture dated as of December 1, 2005 among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc., Wellmont Foundation and the Master Trustee, pursuant to which the Series 2005 Obligations were issued.

"S&P" means Standard & Poor's Ratings Services, a Division of The McGraw-Hill Companies, Inc., a corporation organized and existing under the laws of the State of New York, its successors and assigns, and, if such corporation is dissolved or liquidated or no longer performs the functions of a securities rating agency, "S&P" will be deemed to refer to any other nationally recognized securities rating agency designated by the Corporation by written notice to the Bond Trustee.

"State" means the State of Tennessee.

"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, (a) all Obligations issued pursuant to the Master Indenture, and (b) all other obligations of the Obligated Group thereunder, 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 the Master Indenture, and such "event of default" shall not have been cured or waived or shall not have ceased to exist; and (c) 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.

"Supplemental Indenture" means an indenture supplemental to, and authorized and executed pursuant to, the terms of the Master Indenture.

"Tax Compliance Agreement" means the Tax Compliance Agreement dated as of May 1, 2011 between the Issuer and the Corporation.

"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.

"Tenth Supplemental Master Indenture" means the Tenth Supplemental Master Indenture dated as of November 1, 2010 among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2010 Obligation was issued.

"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 Combined Group for such period, determined in such a manner that no portion of Income Available for Debt Service of any member of the Combined Group is included more than once, plus (b) the Income Available For Debt Service of each Limited Obligor up to an amount equal to the amount of such Limited Obligor's Debt Service Requirement for such period with respect to the Indebtedness of such Limited Obligor guaranteed by a member of the Combined Group.

"Total Net Operating Revenues" means, as to any period, the aggregate of Net Operating Revenues of each member of the Combined Group for such period, determined in such a manner that no portion of Net Operating Revenues of any member of the Combined Group is included more than once.

"Trust Estate" means the property conveyed to the Bond Trustee pursuant to the Granting Clauses of the 2011 Bond Indenture.

"Twelfth Supplemental Master Indenture" means the Twelfth Supplemental Master Indenture dated as of May 1, 2011 among among the Corporation (as the successor to Bristol Memorial Hospital), Wellmont Hawkins County Memorial Hospital, Inc., Wellmont Inc., Wellmont Foundation and the Master Trustee pursuant to which the Series 2011 Swap Obligation was issued.

"Unrelated Trade or Business" means an activity which constitutes an "unrelated trade or business" within the meaning of Section 513(a) of the Code without regard to whether such activity results in unrelated trade or business income subject to taxation under Section 512(a) of the Code.

"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) (1) 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 (2) 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.

"Written Request" means with reference to the Issuer, a request in writing signed by the Chairman, Vice-Chairman or Secretary of the Issuer and with reference to the Corporation means a request in writing signed by the President or a Vice President of the Corporation, or any other officers designated by the Issuer or the Corporation, as the case may be.

SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE

The following is a summary of certain provisions of the Master Indenture, to which reference is made for a full and complete statement of its provisions.

Obligations

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. Such Obligations will be secured equally and ratably by the assignment and pledge to the Master Trustee of a security interest in all money and Investment Securities, if any, held from time to time by the Master Trustee in the funds and accounts established under the Master Indenture and in all Pledged Notes

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 (a) the date of the delivery of the Master Indenture, or (b) 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 Combined Group during such period, such calculations shall be made assuming that such Obligated Issuer became a member of the Combined 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. Further, each Obligated Issuer shall cause, to the extent permitted by law, its Restricted Affiliates to transfer to the Obligated Group such of their property as shall be necessary to enable the Obligated Group to meet all of its joint and several liability (determined without regard to the aggregate Maximum Guaranty Liability of the Obligated Issuers) in respect of all Outstanding Obligations, in the maximum amount permissible under the applicable fraudulent conveyance or similar laws.

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 by such Obligated Issuer pursuant to the Master Indenture; provided, however, that no Obligated Issuer shall be entitled to enforce or receive any payments arising out of, or based upon such right of subrogation until all Obligations shall have been paid in full and discharged.

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 (a) 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 (b) 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 of or interest on any Obligation (in which event this clause (b) shall cease to apply to such person at such time as such default shall be cured).

If an Obligated Issuer is called upon to make a payment under its Cross Guarantee, each of the Obligated Issuers will contribute to such paying Obligated Issuer their pro rata share, determined pursuant to the Master Indenture, of the amount of such payment.

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 (a) the names and addresses of Holders of Obligations, and (b) any other information which may be necessary for the proper discharge of the Master Trustee's duties under the Master Indenture. The Obligations of any series may be transferred or exchanged in the manner specified in the Supplemental Indenture providing for the issuance thereof.

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 (a) if the applicable Supplemental Indenture provides for the making of deposits directly with the Master Trustee in respect of an Obligation, or (b) 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 (a) 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 (b) 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 Holders as provided in the Master Indenture. 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 (a) 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 (b) 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, as evidenced by an opinion of Counsel to that effect delivered to the Master Trustee;

(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.

Persons Becoming Obligated Issuers

The Master Indenture permits Persons other than the Corporation to become members of the Obligated Group subject to the satisfaction of certain conditions. These conditions include the following:

First, such Person must execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Obligated Group Agent, containing (a) 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; (b) the agreement of such Person to consult with each other member of the Obligated Group prior to incurring any Obligations; and (c) such other restrictions on the ability of such Person to incur Obligations as may be imposed by the Obligated Group.

Second, each instrument executed and delivered to the Master Trustee as described in the preceding paragraph must 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 instrument delivered by the Person seeking to become a member of the Obligated Group has been duly authorized, executed and delivered by such Person and constitutes a legal, valid and binding agreement of such Person, enforceable in accordance with its terms, except as limited by then existing laws relating to bankruptcy and insolvency and other standard 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 must 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 must receive:

An Officer's Certificate from the Obligated Group Agent to the effect that (i) 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 (ii) either (A) if one dollar of Additional Indebtedness were incurred immediately following such Person's admission, the Combined Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to the Master Indenture and described in (a)(1) or (2) under "- Additional Long Term Indebtedness" below (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 (B) such Person becoming a member of the Obligated Group will cure any "event of default" then in existence under the Master Indenture, or (C) 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.

Withdrawal from Obligated Group

No Obligated Issuer may withdraw from the Obligated Group unless:

(a) If the Obligated Issuer is other than the Obligated Group Agent, the Obligated Group Agent consents to the withdrawal;

(b) 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 receives an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law such Obligated Issuer'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;

(c) The Master Trustee receives 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 the Master Indenture, 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;

(d) The Master Trustee receives 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" thereunder; and

(e) The Obligated Group Agent receives an opinion of Counsel to such Person 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 will 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.

Conditions for Designation of Restricted Affiliates

Any Affiliate of an Obligated Issuer that satisfies the definition of "Restricted Affiliate" will become a Restricted Affiliate upon delivery to the Master Trustee of the following documents:

(a) an Officer's Certificate from the Obligated Group Agent to the effect that the Obligated Group Agent consents to such Person becoming a Restricted Affiliate;

(b) a written undertaking for the benefit of the Master Trustee duly authorized and executed by such Affiliate evidencing the agreement of such Affiliate (1) to observe and perform the obligations that the Obligated Group has covenanted to cause Restricted Affiliates to observe and perform under the Master Indenture, and (2) subject to any applicable legal restrictions relating to dispositions of assets by organizations described in Section 501(c)(3) of the Code, that upon the liquidation or dissolution of such Affiliate, all remaining assets thereof shall be transferred to an Obligated Issuer, a specified Obligated Issuer, or another Restricted Affiliate;

(c) evidence of appropriate action of the Governing Body of such Affiliate authorizing such undertaking;

(d) an opinion of Counsel to the effect that the conditions contained in the Master Indenture relating to designation of a Restricted Affiliate have been satisfied and an opinion of Counsel to the effect that the instrument described in subparagraph (b) above has been duly authorized, executed and delivered by such Person and constitutes a legal, valid and binding agreement of such Person, enforceable in accordance with its terms, subject only to and limited by the then existing law relating to bankruptcy and insolvency and other standard and customary legal exceptions; and

(e) an Officer's Certificate of the Obligated Group Agent to the effect that (1) 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 (2) either (i) if one dollar of Additional Indebtedness were incurred immediately following the designation of such Affiliate, the Combined Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to the Master Indenture and described in (a)(1) or (2) under "- Additional Long Term Indebtedness" below, or (ii) such Person becoming a Restricted Affiliate will cure any "event of default" then in existence under the Master Indenture, or (iii) by reason of such status, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years following such designation as a Restricted Affiliate will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such designation of such Person as a Restricted Affiliate not occurred.

Release of Restricted Affiliates

Any Person shall be released from its obligations and status as a Restricted Affiliate only upon the following conditions:

(a) The Master Trustee receives an Officer's Certificate from the Obligated Group Agent consenting to the release of such Person from its status as a Restricted Affiliate and certifying that either (1) if one dollar of Additional Indebtedness were incurred after giving effect to such release, the Obligated Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to the Master Indenture and described in (a)(1) or (2) under "- Additional Long Term Indebtedness" below or (2) such release will cure any "event of default" then in existence under the Master Indenture, or (3) by reason of such release, 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 release not occurred.

(b) The Master Trustee receives an Officer's Certificate of the Person requesting such release stating that all conditions precedent provided for under the Master Indenture relating to the release of such Person as a Restricted Affiliate have been complied with and that, were such Person released as a Restricted Affiliate on the date of such Officer's Certificate, no "event of default" would then exist under the Master Indenture, nor to such officer's knowledge, would 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" thereunder.

(c) Upon compliance with the conditions described in subparagraphs (a) and (b) above, the Master Trustee will execute any documents reasonably requested by the released Person to evidence the termination of such Person's status as a Restricted Affiliate.

Short-Term Indebtedness

Each Obligated Issuer has agreed 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) (1) the principal amount of all Short-Term Indebtedness of the Combined 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, or

(2) 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 commencing July 1, 1991, the Combined Group reduces the aggregate principal amount of all Outstanding Short-Term Indebtedness described in (a)(1) above to less than 5% of the Total Net Operating Revenues for the immediately preceding Fiscal Year.

Additional Long-Term Indebtedness

Each Obligated Issuer has agreed 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 Combined Group, if prior to the incurrence thereof, there is delivered to the Master Trustee:

(1) 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 1.20; or

(2) (i) an Officer's Certificate of the Obligated Group Agent demonstrating that the Historical 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 1.10, and (ii) 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 clause (ii) 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 1.20.

The requirements described in (a)(2)(i) and (ii) above will be deemed satisfied if (A) 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, and (B) the Combined Group has generated Total Income Available for Debt Service in an amount which, in the opinion of such Consultant, the Combined Group could reasonably have generated given such laws and regulations during the period affected thereby.

(b) Completion Indebtedness of any member of the Combined Group without limit if there is delivered to the Master Trustee: (1) an Officer's Certificate of the applicable member of the Combined Group stating that at the time the original Long-Term Indebtedness for the Facilities to be completed was incurred, such Combined 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; (2) a statement of an Architect setting forth the amount estimated to be needed to complete the Facilities, and (3) an Officer's Certificate of such member of the Combined 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 Combined 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 (2).

(c) Commitment Indebtedness of any member of the Combined 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 Combined Group incurred for the purpose of refunding, repurchasing or refinancing (whether in advance or otherwise) any outstanding Long-Term Indebtedness;

(e) The conversion without limit of Long-Term Indebtedness of any member of the Combined Group that is convertible from one interest or payment mode to another interest or payment mode (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 Combined Group or Non-Recourse Indebtedness without limit of any member of the Combined Group;

(g) Indebtedness incurred in connection with a sale of accounts receivable with recourse by any member of the Combined 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 may not exceed the aggregate sales price of such accounts receivable received by such Combined Group member;

(h) Long-Term Indebtedness of any member of the Combined Group, the principal amount of which at the time incurred, together with the aggregate principal amount of all other Long-Term Indebtedness of the Combined 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 Combined 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 Combined Group will not exceed 66-2/3% of the Capitalization.

Guaranties

(a) Each Obligated Issuer has agreed 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.

(b) In the case of Guaranties of indebtedness that would, if such indebtedness were incurred by a member of the Combined Group, constitute Long-Term Indebtedness, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty will 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, the aggregate annual principal and interest payments on, and the principal amount of, the Guaranty will, 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 in which payment is made.

Limited Obligors

(a) Any Person may become a Limited Obligor upon delivery to the Master Trustee of the following:

(1) An Officer's Certificate from the Obligated Group Agent to the effect that the Obligated Group Agent consents to such Person becoming a Limited Obligor;

(2) An opinion of Counsel to the effect that the Pledged Note (i) has been duly authorized, executed and delivered by the Limited Obligor and (ii) constitutes the legal, valid and binding obligation of the Limited Obligor, enforceable in accordance with its terms, subject only to and limited by the then existing law relating to bankruptcy and insolvency and other customary and standard legal exceptions, and an opinion of Counsel to the applicable Obligated Issuer to the effect that the Pledged Note has been validly assigned by the applicable Obligated Issuer to the Master Trustee; and

(3) The duly executed Pledged Note made by such Person.

(b) Any Person may be released from its obligations and status as a Limited Obligor upon the following conditions:

(1) The Master Trustee receives an Officer's Certificate from the Obligated Group Agent consenting to the release of such Person from its status as a Limited Obligor and certifying that immediately after the release of such Person, no "event of default" then exists under the Master Indenture, nor to such officer's knowledge, would 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" thereunder; and

(2) The Master Trustee receives an Officer's Certificate from the Obligated Group Agent to the effect that either (i) after giving effect to such release, if one dollar of Additional Indebtedness were incurred, the Combined Group would meet the test providing for the incurrence of Long- Term Indebtedness pursuant to Section 4.2(a)(i) or (ii) of the Master Indenture, or (ii) by reason of such release, the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following such release will be greater then the Projected Debt Service Coverage Ratio for such Fiscal Years had such release not occurred, or (iii) such Person has become a member of the Combined Group.

(c) Upon compliance with the conditions described in subparagraph (b) above, the Master Trustee will surrender the Pledged Note to the released Person, duly marked "cancelled" and will execute such other documents reasonably requested by such Person to evidence the termination of such Person's status as a Limited Obligor.

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 will be assumed, at the discretion of the Obligated Group Agent, as the case may be, that (a)the interest rate on Variable Rate Indebtedness is equal to that rate derived from the Bond Index and (b) the principal of Balloon Indebtedness is amortized:

(1) from the date of calculation thereof over a term of thirty (30) years with level annual debt service payments at an assumed interest rate equal to the Bond Index; or

(2) 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

(3) the principal of Balloon Indebtedness is due and payable on the specified due date or due dates thereof; or

(4) 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.

Insurance

Each Obligated Issuer have covenanted that it will maintain, or cause to be maintained, and will require each of its Restricted Affiliates to 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 or Restricted Affiliate is a health care institution) professional liability or medical malpractice insurance. 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 three years (such report to be filed as soon as practicable but in no event later than five months after the end of the applicable third Fiscal Year). Each Obligated Issuer will follow, and will require each of its Restricted Affiliates to 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 described above, the Combined Group, or any member thereof, may self-insure any of the required coverages (or a portion thereof), provided 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 Combined Group elects to self-insure in lieu of maintaining medical liability and malpractice insurance, a report of an Insurance Consultant must be filed with the Master Trustee annually stating that such Insurance Consultant has reviewed the self-insurance program and that the self-insured Combined 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 Combined Group with a Value in excess of five percent (5%) of the Value of all Property of the Combined Group, the affected Combined Group member or the Obligated Group Agent will exercise its best efforts to recover any applicable insurance. Such proceeds will be paid to the Obligated Group Agent for the payment or reimbursement of reasonable expenses of obtaining the recovery. The Obligated Group Agent will 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 Combined Group member will apply the Net Proceeds for any lawful corporate purpose as such Combined Group member determines, if the Obligated Group Agent first delivers 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 such an Officer's Certificate, the affected Combined Group member must 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 Combined 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 determines.

Any Net Proceeds remaining after compliance by the affected Combined Group member and the Obligated Group Agent with the provisions of the Master Indenture described in the immediately preceding paragraph will be transferred by the Obligated Group Agent to the Master Trustee and applied to the redemption of the Outstanding Obligations in such order of maturity or maturities or proportions as the Obligated Group Agent determines.

In the event of a taking by eminent domain of all or any part of the Facilities of the Combined Group with a Value in excess of five percent (5%) of the Value of all Property of the Combined Group, the affected Combined Group member or the Obligated Group Agent will exercise its best efforts to recover any applicable proceeds. Such proceeds shall be paid to the Obligated Group Agent. The Obligated Group Agent will 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 as described in the two immediately preceding paragraphs.

Certain Covenants of the Obligated Issuers

Each Obligated Issuer has covenanted (and will cause each of its Restricted Affiliates to comply with such 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 or Restricted Affiliate thereof 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 (subject to certain exceptions set forth in the Master Indenture), and not to discriminate on any legally impermissible basis.

In addition, each Obligated Issuer has covenanted not to merge with or consolidate with any other Person not a member of the Combined Group or sell or convey all or substantially all of its assets to any Person not a member of the Combined Group unless: (a) the successor corporation (if other than the Obligated Issuer)is a Person organized and existing under the laws of the United States of America or a state thereof and such Person becomes an Obligated Issuer and expressly assumes 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 must receive 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, (i) 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 (ii) either (A) 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 Section 4.2(a)(i) or (ii) of the Master Indenture (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 (B) 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.

In case of any such consolidation, merger, sale or conveyance and upon any such assumption by the successor corporation, such successor corporation will 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 may 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 has agreed that it will not, nor will it permit any of its Restricted Affiliates to, sell, lease or otherwise dispose of any Property, except for sales, leases or other dispositions of Property:

(a) To another member of the Combined 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 the 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 that Property transferred as described in this subparagraph (c) in the then-current Fiscal Year by all Obligated Issuers and Restricted Affiliates does not exceed 10% of the Value of all Property of the Combined 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 Combined Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to Section 4.2(a)(i) or (ii) of the Master Indenture 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 by the Master Indenture;

(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) Certain Property specified in the Master Indenture, which Property may be transferred at any time, at the option of the Obligated Group Agent, notwithstanding anything to the contrary contained in the Master Indenture as described above.

Disposition of Restricted Affiliates

No Obligated Group Member may:

(a) Permit any of its Restricted Affiliates to issue or sell any shares of stock of such Restricted Affiliate to any Person (other than members of the Combined Group and except for director's qualifying shares), except for the purpose of paying a common stock dividend on, or splitting the common stock of such Restricted Affiliate; or

(b) Sell, transfer, or otherwise dispose of any shares of stock (except to members of the Combined Group) of any Restricted Affiliates or permit any of its Restricted Affiliates to sell, transfer, or otherwise dispose of (except to members of the Combined Group) any shares of stock of any other Restricted Affiliate, unless all shares of stock of such Restricted Affiliate owned by the members of the Combined Group are sold, transferred or disposed of and either (1) after giving effect to such disposition if one dollar of Additional Indebtedness were incurred, the Combined Group would meet the test providing for the incurrence of Long-Term Indebtedness pursuant to Section 4.2(a)(i) or (ii) of the Master Indenture, or (2) the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following such disposition will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such disposition not occurred; or

(c) Permit any of the Restricted Affiliates to consolidate with or merge into any other corporation or to transfer all or substantially all of its assets as an entirety to another Person, unless the successor formed by such consolidation or into which the Restricted Affiliate is merged or the Person which acquires by conveyance or transfer the assets of the Restricted Affiliate substantially as an entirety is a member of the Combined Group or, if such successor or the transferee is not a member of the Combined Group, either (1) after giving effect to such consolidation, merger or transfer 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 Section 4.2(a)(i) or (ii) of the Master Indenture, or (2) the Projected Debt Service Coverage Ratio for each of the two Fiscal Years immediately following such consolidation, merger or transfer will be greater than the Projected Debt Service Coverage Ratio for such Fiscal Years had such consolidation, merger or transfer not occurred.

Filing of Financial Statements, Certificate of No Default, Other Information

The Obligated Group Agent has covenanted that it will:

(a) As soon as practicable but in no event later than five 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, (1) a combined or consolidated revenue and expense statement of the Corporation, each other Obligated Issuer and each Restricted Affiliate, for such Fiscal Year and (2) a combined or consolidated balance sheet of the Corporation, each other Obligated Issuer and each Restricted Affiliate 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 five months after the end of each Fiscal Year, file with the Master Trustee (1) a written statement of the Accountant whose report accompanies the financial statements referred to in (a) above stating the Historical Debt Service Coverage Ratio and the Historical Maximum Annual Debt Service Coverage Ratio for such Fiscal Year, and (2) an Officer's Certificate of the Obligated Group Agent stating that all insurance required under 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.

(c) If an "event of default" has occurred and is continuing under the Master Indenture, (1) 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 (2) 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.

Rates and Charges

Each Obligated Issuer has covenanted and agreed that it will, and cause each of its Restricted Affiliated to, 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, 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 a ratio of Total Income Available For Debt Service to Maximum Annual Debt Service at least equal to 1.10:1. Each Obligated Issuer has further covenanted and agreed that it will from time to time as often as necessary and to the extent permitted by law, revise, and cause each of its Restricted Affiliates to 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 herein.

If in any Fiscal Year the Historical Maximum Annual Debt Service Coverage Ratio of the Combined Group is less than 1.10:1, the Master Trustee will 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 Combined 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 1.10:1.

A copy of the Consultant's report and recommendations, if any, will be filed with each Obligated Issuer, the Master Trustee, each Related Issuer and each Related Bond Trustee. Each Obligated Issuer must follow, and cause each of its Restricted Affiliates to 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. The provision of the Master Indenture herein described will not be construed to prohibit any Obligated Issuer or Restricted Affiliate from serving indigent patients to the extent required for such Obligated Issuer or Restricted Affiliate 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 Combined Group from satisfying the other

requirements of the Master Indenture herein described. So long as the Obligated Group retains a Consultant and follows such Consultant's recommendations to the extent permitted by law, the provisions of the Master Indenture herein described will be deemed to have been complied with even if such ratio for any subsequent Fiscal Year is below 1:10:1; provided, however, that in no event may the Historical Maximum Annual Debt Service Coverage Ratio for any year be less than 1:00:1.

The foregoing provisions of the Master Indenture notwithstanding, if in any Fiscal Year the Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group is less than 1.10:1, the Master Trustee will not be obligated to require the Obligated Group to retain a Consultant to make such recommendations if: (a) (1) there is filed with the Master Trustee (who will provide a copy to each Related Bond Trustee and Related Issuer) a written report addressed to them of a Consultant (which Consultant and report, including without limitation the scope, form, substance and other aspects of such report, are acceptable to the Master Trustee) which contains an opinion of such Consultant that applicable laws or regulations have prevented the Combined Group from generating Income Available for Debt Service during such Fiscal Year in an amount sufficient to attain a Historical Maximum Annual Debt Service Coverage Ratio of at least 1.10:1 and, if requested by the Master Trustee, such report is accompanied by a concurring opinion of Counsel (which Counsel and opinion, including without limitation the scope, form, substance and other aspects thereof, are acceptable to the Master Trustee) as to any conclusions of law supporting the opinion of such Consultant; and (2) the report of such Consultant indicates that the rates charged by the Obligated Group are such that, in the opinion of the Consultant, the Obligated Group has generated the maximum amount of revenues reasonably practicable given such laws or regulations; or (b) there is filed with the Master Trustee (who will provide a copy to each Related Bond Trustee and Related Issuer) an Officer's Certificate of the Obligated Group Agent stating that a Consultant's report described in the second paragraph under the heading "- Rates and Charges" has been filed previously, the facts and assumptions therein have not materially changed and the Obligated Group is continuing to use its best efforts to implement the Consultant's recommendations.

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 Obligation 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 will 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 must 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 done, taken or remedied, within such 30-day period, no "event of default" will be deemed to have occurred or to exist if, and so long as, the defaulting Obligated Issuer commences such observance or performance within such 30-day period and diligently and continuously prosecutes the same to completion; or

(c) (1) 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 Combined Group for the immediately preceding Fiscal Year, whether such Indebtedness now exists or is created after the date of the Master Indenture and any grace period with respect thereto expires, or (2) any "event of default" as defined in any Related Financing Documents under which any such Indebtedness may be issued, secured or evidenced occurs, 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 (1) the Obligated Issuer commences proceedings to contest the existence or payment of such Indebtedness, and (2)

in the absence of such contest, neither the pledge and security interest created under the Master Indenture nor any Property of the Combined 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 as provided in the Master Indenture.

Upon the occurrence of an "event of default" under the Master Indenture, 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 will be required to make such a declaration (1) if an "event of default" has occurred as described in subparagraph (a) above, (2) if an "event of default" has occurred as described in subparagraph (b) above as a result of a default under the Related Financing Documents for any Obligations, if the Related Financing Documents permit the Holders of such Obligations to declare (or to request the Master Trustee to declare) such Obligations to be immediately due and payable and if the Master Trustee is requested to make such a declaration by the Holders of not less than 25% in aggregate principal amount of such Obligations then Outstanding or such greater percentage as may be required under the Related Financing Documents, or (3) 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.

Any acceleration of the principal of the Obligations as described in the preceding paragraph will be subject to the condition that if, at any time after the principal of all Outstanding Obligations has been accelerated, and before any judgment or decree for the payment of the moneys due has been obtained or entered: (a) one or more Obligated Issuers deposits with the Master Trustee an aggregate sum sufficient to pay (1) 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, (2) all amounts due under each Indenture Guaranty other than by reason of acceleration, (3) all sums due under any Obligations other than Notes and Indenture Guaranties, other than by reason of acceleration, and (4) the expenses and fees of the Master Trustee; and (b) 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, are remedied, then and in every such case, the Master Trustee will, if requested by the Holders of 25% in aggregate principal amount of all Obligations then Outstanding, waive all "events of default" under the Master Indenture and rescind and annul such declaration and its consequences, but no such waiver or rescission and annulment will extend to or effect any subsequent "event of default" under the Master Indenture.

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 whole 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 Group wherever situated.

If there are pending proceedings for the bankruptcy or for the reorganization of any Obligated Issuer, or if a receiver or trustee is appointed for its Property, the Master Trustee will 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 is a party) the Master Trustee will be held to represent all the Holders of Obligations, and it will 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" under the Master Indenture 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 has become or has 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 will 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 as described in this subparagraph (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.

Actions by Holders

(a) No Holder of an Obligation has 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 have made written request upon the Master Trustee to institute such action, suit or proceeding in its own name as Master Trustee and 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, neglects or refuses to institute any such action, suit or proceeding and no direction inconsistent with such written request has 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 will 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 will 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 in the Master Indenture and more fully set forth therein will be entitled in such suit, action or proceeding to such amounts as may 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, may 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) will 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 a majority in aggregate principal amount of Obligations then Outstanding 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 has 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, by a responsible officer or officers of the Master Trustee, determines that the proceedings so directed would be illegal or involve it in personal liability, and provided further that nothing in the Master Indenture will impair the right of the Master Trustee in its discretion to take any action deemed proper by the Master Trustee and which is not inconsistent with such direction by the Holders. The Master Trustee may require, at its option, that prior to taking any action under the Master Indenture, it be provided indemnity with respect to the taking of such action satisfactory to the Master Trustee.

Notice of Default

The Master Trustee will, within 10 days after the occurrence of an "event of default" under the Master Indenture known to the Master Trustee, mail to all Holders of Obligations, as the names and addresses of such Holders appear upon the books maintained by the Master Trustee, notice of such "event of default" under the Master Indenture known to the Master Trustee, unless such "event of default" has been cured before the giving of such notice; provided that, except in the case of a payment default on any Obligation, the Master Trustee will 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 will 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" under the Master Indenture and after the curing or waiving of all such "events of default" which may have occurred, the Master Trustee has undertaken to perform only those duties specifically set forth in the Master Indenture. If such an "event of default" occurs and is not cured or waived, the Master Trustee will exercise the rights and powers vested in it by the Master Indenture, and use the same degree

of care and skill in their exercise as a prudent man would exercise or use under the circumstances in the conduct of his own affairs.

No provision of the Master Indenture will 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:

(1) the Master Trustee will 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 proved that the Master Trustee was grossly negligent in ascertaining the pertinent facts, other than facts which the Master Trustee in not required to investigate as provided in the Master Indenture; and

(2) the Master Trustee will 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 described in the immediately preceding paragraphs:

(a) The Master Trustee may rely and will be protected in acting or refraining from acting upon various papers or documents believed by it in good faith 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) will 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 will be full and complete authorization and protection. The Master Trustee will 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 is 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) will be taken as the statements of the Obligated Issuers, 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 is not accountable for the use or application by any Obligated Issuer 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 does 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 will eliminate the conflict or resign as Master Trustee.

Each Obligated Issuer will pay, and will be jointly and severally liable to pay, to the Master Trustee reasonable compensation and reimbursement for all reasonable expenses, disbursement and advances incurred or made by the Master Trustee in connection with the acceptance or administration of its trusts under the Master Indenture. Each Obligated Issuer will indemnify, defend and will 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 herein will 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 will have an express first and prior lien on any moneys or Investment Securities on deposit in any funds established under the Master Indenture as security for the payment of all such obligations.

Subject to the provisions of the Master Indenture described in the first paragraph under "- 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 willful misconduct or gross negligence on the part of the Master Trustee, any such Officer's Certificate will 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 will 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 provided in 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 and such other notice required by the Master Indenture, 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 will promptly give notice of any removal as described in 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, must accept such appointment in writing, and, without further act, will 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, must 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 is a party, or any corporation to which substantially all the business of the Master Trustee may be transferred, will, subject to the provisions of the Master Indenture described in the immediately preceding paragraph, be the Master Trustee under the Master Indenture without further act.

Subject to the terms and conditions set forth in the Master Indenture, the Master Trustee will have the power to appoint one or more Persons not unsatisfactory to the Obligated Group Agent to act as Co-Master Trustee as provided in the Master Indenture.

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 Maser Indenture or adversely affect the Holders of any particular Obligations or 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 otherwise provided therein), (h) reflect a change in applicable law, and (i) modify, amend, change or remove any covenant, agreement, term or provision of the Master Indenture (other than a modification of the type described in the immediately following paragraph hereof requiring the unanimous written consent of the Holders), provided that either of the following conditions is satisfied prior to the effective date of such Supplemental Indenture: (x) if at the time of the proposed amendment, the Obligations or any series of Related Bonds are rated by one or more Rating Agencies, written notice of the substance of such proposed amendment is given to such Rating Agencies by the Obligated Group Agent not fewer than 30 days prior to the date such amendment is to take effect, and the Obligated Group Agent provides evidence satisfactory to the Master Trustee that the ratings on the Obligations or any series of Related Bonds will not be lowered or withdrawn by such Rating Agencies as a result of such proposed amendment; or (y) a Consultant's report is delivered to the Master Trustee prior to the date such amendment is to take effect, to the effect that the proposed amendment is consistent with then current industry standards for comparable institutions and demonstrating either that (1) the Projected Debt Service Coverage Ratio for the full Fiscal Year immediately after the effective date of such proposed amendment is not less than 1.20, assuming the maximum implementation (or such lower implementation certified to the Master Trustee by the Obligated Group Agent as being a reasonable basis for assumption) by the Obligated Group of the proposed amendment; or (2) if the proposed amendment is to a provision of the Master Indenture that contains a quantitative restriction or covenant, the average of the Projected Debt Service Coverage Ratio for the two full Fiscal Years immediately after the effective date of such proposed amendment or supplement will be greater than the average of the Debt Service Coverage Ratio for such period had the proposed amendment not been implemented, assuming the maximum implementation (or such lower implementation certified to the Master Trustee by the Obligated Group Agent as being a reasonable basis for assumption) of the proposed amendment; or (3) (A) the average of the Projected Debt Service Coverage Ratio for the two full Fiscal Years immediately after the effective date of such proposed amendment will not be less than 1.10, and (B) the average of the Projected Debt Service Coverage Ratios for the two full Fiscal Years immediately after the effective date of such proposed amendment will not be more than 35% lower than the average of the Debt Service Coverage Ratios had the proposed amendment not been implemented, assuming with respect to the projections made under (A) and (B) the maximum implementation (or such lower implementation certified to the Master Trustee by the Obligated Group Agent as being a reasonable basis for assumption) of the proposed amendment if the proposed amendment is to a provision of the Master Indenture that contains a quantitative restriction or covenant.

Each Obligated Issuer, when authorized by its Governing Body, and the Master Trustee may, with the consent of the Holders of a majority in aggregate principal amount of Obligations then Outstanding, otherwise amend or supplement the Master Indenture, subject to the provisions contained in the Master Indenture; provided, however, that (a) without the consent of the Holders of all Obligations whose Obligations are proposed to be modified, no such Supplemental Indenture may 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 or Obligations over any other Obligation or Obligations, and (b) without the consent of the Holders of all Obligations

then Outstanding, no such Supplemental Indenture may reduce the aforesaid percentage or affected class of Obligations, the Holders of which are required to consent to any such Supplemental Indenture.

Effect of Supplemental Indenture

Upon the execution of any Supplemental Indenture, the Master Indenture will 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 will 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 will be deemed to be part of the terms and conditions of the Master Indenture.

Immunity of Incorporators, Members, Officers and Members of Governing Body

No recourse under or upon any obligation, covenant or agreement of the Master Indenture, or of any Obligations issued under the Master Indenture, or for any claim based thereon or otherwise in respect thereof, may be had against any incorporator, member, officer or member of the Governing Body, as such, past, present or future, of any Obligated Issuer or of any successor corporation, either directly or through such Obligated Issuer, whether by virtue of any constitution, statute or rule of law, or by the enforcement of any assessment or penalty or otherwise.

Immunity of Officers, Employees and Directors of the Master Trustee

No recourse may be had by the Obligated Group, the Issuer or any Holder for any claim based upon the Master Indenture or any Obligation issued thereunder against any director, officer or employee of the Master Trustee unless such claim is based on bad faith, fraud, deceit or other willful misconduct of such Person or the gross negligence of such Person.

Satisfaction and Discharge of Indenture

If the Master Trustee receives: (a) an amount which is (1) in the form of (i) cash, or (ii) Government Obligations, and (2) in a principal amount sufficient, as determined in the sole and absolute discretion of the Master Trustee, 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; (c) an amount sufficient, as determined in the sole and absolute discretion of the Master Trustee, to pay or provide for the payment of all other sums payable under the Master Indenture by the Obligated Issuers or any thereof; and (d) a verification report of an independent nationally recognized certified public accounting firm that the principal and interest becoming due on Government Obligations held by the Master Trustee after such transaction and any other moneys available therefor will provide the Master Trustee with moneys which at all times will be sufficient to pay the principal, premium, if any, and interest on the outstanding Obligations, then the Master Indenture will cease to be of further effect, and the Master Trustee, on demand of the Obligated Group Agent, will 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 (or a portion thereof) at or prior to maturity, and the Obligation (or portion thereof) so provided for will 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 will, upon surrender to the Master Trustee for cancellation, no longer be deemed Outstanding under the Master Indenture.

Fifth Supplemental Master Indenture, Sixth Supplemental Master Indenture; and Eighth Supplemental Master Indenture

The Fifth Supplemental Master Indenture, the Sixth Supplemental Master Indenture and Eighth Supplemental Master Indenture contain terms and provisions in addition to those described above that apply only so long as the Series 2003 Obligation, the Series 2005 Obligations and the Series 2006C Obligation, respectively, remain Outstanding.

SUMMARY OF CERTAIN PROVISIONS OF THE 2011 BOND INDENTURE

The 2011 Bond Indenture contains various covenants, security provisions, terms and conditions, certain of which are summarized below. Reference is made to the 2011 Bond Indenture for a full and complete statement of its provisions.

Payment of Principal, Premium, if any, and Interest

The Issuer has covenanted that it will promptly pay or cause to be paid the principal of, premium, if any, and interest on every Series 2011 Bond issued under the 2011 Bond Indenture at the place, on the dates, and in the manner provided therein and in said Series 2011 Bonds according to the true intent and meaning thereof, but solely from the amounts pledged therefor. Neither the Issuer, the State, nor any political subdivision of the State will in any event be liable for the payment of the principal of, premium, if any, or interest on any of the Series 2011 Bonds or for the performance of any pledge, obligation or agreement undertaken by the Issuer except to the extent that the moneys pledged in the 2011 Bond Indenture are sufficient therefor. No Owner of any Series 2011 Bond has the right to compel any exercise of taxing power of the State or any political subdivision thereof to pay the Series 2011 Bonds or the interest thereon, and the Series 2011 Bonds do not constitute an indebtedness of the Issuer, the State or any political subdivision of the State, or a loan of credit of any of the foregoing within the meaning of any constitutional or statutory provision.

Revenues and Funds

Bond Fund. The 2011 Bond Indenture creates and establishes with the Bond Trustee a trust fund to be designated "The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee - Bond Fund, Wellmont Health System," which will be used to pay when due the principal of, premium, if any, and interest on the Series 2011 Bonds. The Bond Trustee will make a deposit from the proceeds of the Series 2011 Bonds representing accrued interest on the Series 2011 Bonds in the Costs of Issuance Fund on the date of issuance of the Series 2011 Bonds, as described under "Sources and Uses of Funds" in this Official Statement. There will be deposited into the Bond Fund from time to time, all moneys received by the Bond Trustee under and pursuant to any of the provisions of the 2011 Bond Indenture, the Loan Agreement, the Series 2011 Obligation or otherwise which are required to be or which are accompanied by directions that such moneys are to be paid into the Bond Fund. Except as otherwise specifically provided in the 2011 Bond Indenture, moneys in the Bond Fund will be used solely for the payment of the principal of, premium, if any, and interest on the Series 2011 Bonds and for the redemption of the Series 2011 Bonds prior to maturity.

Costs of Issuance Fund. The Trustee will make a deposit from the proceeds of the Series 2011 Bonds in the Costs of Issuance Fund on the date of issuance of the Series 2011 Bonds. Amounts in the Costs of Issuance Fund will be disbursed by the Bond Trustee to pay Costs of Issuance upon receipt of a Written Request by the Corporation which states the amount to be paid, the payee and the purpose for such payment. Upon the receipt of Written Request from the Corporation or the date that is 120 days following the date of issuance of the Series 2011 Bonds,

whichever date is sooner, the Bond Trustee will transfer amounts remaining in the Costs of Issuance Fund to the Bond Fund to be applied as provided in the 2011 Bond Indenture.

Nonpresentment of Bonds. If any Series 2011 Bond is not presented for payment when the principal thereof becomes due, either at maturity, or at the date fixed for redemption thereof, or otherwise, if moneys sufficient to pay any such Series 2011 Bond have been deposited with the Bond Trustee for the benefit of the Owner thereof, all liability of the Issuer to the Owner thereof for the payment of such Series 2011 Bond will forthwith cease, determine and be completely discharged, and thereupon it will be the duty of the Bond Trustee to hold such funds, uninvested or invested in Government Obligations maturing overnight, but in any event without liability for interest thereon, for the benefit of the Owner of such Series 2011 Bond, to which funds the Owner will thereafter be restricted exclusively for any claim of whatever nature on its part under the 2011 Bond Indenture with respect to such Series 2011 Bond.

Any moneys so deposited with and held by the Bond Trustee not so applied to the payment of Series 2011 Bonds within two years after the date on which the same became due will be repaid by the Bond Trustee to the Corporation upon written direction of a Corporation Representative, and thereafter Owners of Series 2011 Bonds will be entitled to look only to the Corporation for payment, and then to the extent of the amount so repaid, and all liability of the Bond Trustee with respect to such money will thereupon cease, and the Corporation will not be liable for any interest thereon and will not be regarded as a trustee of such money.

Moneys to be Held in Trust. All moneys required to be deposited with or paid to the Bond Trustee for the account of any fund or account referred to in any provision of the 2011 Bond Indenture or the Loan Agreement will be held by the Bond Trustee in trust, and, while held by the Bond Trustee, will constitute part of the Trust Estate and be subject to the lien and security interest created thereby, except as otherwise specifically provided in the 2011 Bond Indenture.

Rebate Fund. The 2011 Bond Indenture creates and establishes with the Bond Trustee a trust fund to be held in trust to be designated "The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee Rebate Fund Wellmont Health System." The Bond Trustee will make information regarding the Series 2011 Bonds and the investments under the 2011 Bond Indenture available to the Corporation upon written request, will make deposits to and disbursements from the Rebate Fund in accordance with the directions received from the Corporation or the Corporation Representative, will invest moneys in the Rebate Fund pursuant to said directions and will deposit income from such investments pursuant to said directions, and will make payments to the United States of America in accordance with directions received from the Corporation.

Notwithstanding any provision of the 2011 Bond Indenture to the contrary, the Bond Trustee will not be liable or responsible for any calculation or determination which may be required in connection with or for the purpose of complying with Section 148 of the Code or any applicable Treasury regulation (the "Arbitrage Rules"), including, without limitation, the calculation of amounts required to be paid to the United States under the provisions of the Arbitrage Rules, the maximum amount which may be invested in "nonpurpose obligations" as defined in the Code and the fair market value of any investment made thereunder, it being understood and agreed that the sole obligation of the Bond Trustee with respect to investments of funds under the 2011 Bond Indenture will be to invest the moneys received by the Bond Trustee pursuant to the written instructions of the Corporation Representative given in accordance with the 2011 Bond Indenture and as described under "- Investment of Moneys" below. The Bond Trustee will have no responsibility for determining whether or not the investments made pursuant to the direction of the Corporation Representative or any of the instructions received by the Bond Trustee as described herein comply with the requirements of the Arbitrage Rules and will have no responsibility for monitoring the obligations of the Corporation or the Issuer for compliance with the provisions of the 2011 Bond Indenture with respect to the Arbitrage Rules.

Investment of Moneys

Any moneys held as a part of the Costs of Issuance Fund, upon a Written Request of the Corporation, will be invested or reinvested by the Bond Trustee in Investment Securities maturing at such time or times so that the Bond Trustee will be able to pay the costs of issuance of the Bonds from time to time upon the Written Request of

the Corporation. The Bond Trustee will not be obligated to invest any moneys held by it in the Costs of Issuance Fund except as directed in writing by the Corporation, but will inform the Corporation as soon as practicable of any amounts that remain uninvested but are eligible for investment in Investment Securities.

Any moneys held as a part of the Bond Fund or the Rebate Fund will be invested or reinvested by the Bond Trustee in Government Obligations with such maturities as required in order to assure full and timely payment of amounts required to be paid from such funds, which maturities, in the case of the Bond Fund, may extend no more than 30 days from the date of acquisition thereof.

The Bond Trustee will sell or present for redemption any investments so purchased whenever necessary to provide moneys to meet any payment pursuant to the Bond Indenture and the Bond Trustee will not be liable or responsible for any loss resulting from such investments. The Bond Trustee will not be responsible for any reduction of the value of any investments made in accordance with the Written Request of the Corporation or any losses incurred in the sale of such investments.

The Bond Trustee may make any and all such investments through its own bond or investment department or the bond or investment department of any bank or trust company under common control with the Bond Trustee, and may charge and collect its and/or pay its customary fees and expenses in connection therewith. The Bond Trustee will not be liable for any depreciation in the value of any investment made pursuant to the 2011 Bond Indenture or for any loss arising from any such investment, or any determination that the Series 2011 Bonds are "arbitrage bonds" as a result of any such investments. All such investments will at all times be a part of the fund or account from which the moneys used to acquire such investments have come and all income and profits on such investments will be credited to, and losses thereon will be charged against, such fund. All investments under the 2011 Bond Indenture will be registered in the name of the Bond Trustee, as Bond Trustee under the 2011 Bond Indenture, and will be held by or under the control of the Bond Trustee. The Bond Trustee may conclusively rely upon the Corporation's written instructions as to both the suitability and legality of all directed investments under the Bond Indenture. Ratings of investment shall be determined at the time of purchase of such investments and without regard to ratings subcategories. The Bond Trustee shall have no responsibility to monitor the ratings of investments after the initial purchase of such investments. In the absence of written investment instructions from the Corporation, the Bond Trustee shall not be responsible or liable for keeping the moneys held by it under the Bond Indenture fully invested. Confirmations of investments are not required to be issued by the Bond Trustee for each month in which a monthly statement is rendered.

Notwithstanding any other provisions of the 2011 Bond Indenture described herein, all investment earnings will be subject to the provisions of the Tax Compliance Agreement and Non-Arbitrage Certificate. The Issuer has covenanted and certified to and for the benefit of the Owners of the Series 2011 Bonds from time to time Outstanding that so long as any of the Series 2011 Bonds remain Outstanding, the Issuer will not direct that moneys on deposit in any fund or account in connection with the Series 2011 Bonds (whether or not such moneys were derived from the proceeds of the sale of the Series 2011 Bonds or from any other sources), be used in a manner which will cause the Series 2011 Bonds to be classified as "arbitrage bonds" within the meaning of Section 148 of the Code. Pursuant to such covenants, the Issuer has obligated itself to comply throughout the term of the Series 2011 Bonds with any request of the Corporation regarding the requirements of Section 148 of the Code, and any regulations promulgated thereunder. Notwithstanding any provision of the 2011 Bond Indenture to the contrary, the Bond Trustee will not be liable or responsible for any calculation or determination which may be required in connection with or for the purpose of complying with Section 148 of the Code including, without limitation, the calculation of amounts required to be paid to the United States under the provisions of such Section 148 of the Code, and will be entitled to rely on the directions or the absence of directions of the Corporation and any rebate analyst.

Discharge of Indenture

If the Issuer pays or causes to be paid, in accordance with the provisions of the 2011 Bond Indenture, to the Owners of the Series 2011 Bonds, the principal of, premium, if any, and interest due or to become due thereon at the times and in the manner stipulated therein, and if the Issuer is not then in default in any of the other covenants and promises in the Series 2011 Bonds and in the 2011 Bond Indenture expressed as to be kept, performed and observed by it or on its part, and if the Issuer pays or causes to be paid to the Bond Trustee all sums of money due or to

become due according to the provisions thereof, then the presents and the estate and rights granted by the 2011 Bond Indenture will cease, determine and be void, whereupon the Bond Trustee will cancel and discharge the lien of the 2011 Bond Indenture, and execute and deliver to the Issuer such instruments in writing as are required to release the lien thereof and re-convey, release, assign and deliver to the Issuer any and all of the estate, right, title and interest in and to any and all rights or property conveyed, assigned or pledged to the Bond Trustee or otherwise subject to the lien of the 2011 Bond Indenture, except (i) cash held by the Bond Trustee for the payment of the principal of, premium, if any, or interest on particular Series 2011 Bonds and (ii) amounts in the Rebate Fund required to be paid to the United States.

Defeasance of Bonds

Any Series 2011 Bond will be deemed to be paid within the meaning of the 2011 Bond Indenture and for all purposes thereof when (a) payment of the principal of and premium, if any, on such Series 2011 Bond, plus interest thereon to the due date thereof (whether such due date is by reason of maturity or upon redemption) either (i) have been made or caused to be made in accordance with the terms thereof, or (ii) have been provided for by irrevocably depositing with the Bond Trustee, in trust and irrevocably set aside exclusively for such payment, (1) moneys sufficient to make such payment or (2) Government Obligations maturing as to principal and interest in such amounts and at such times as will insure, without further investment or reinvestment thereof, in the opinion of an independent certified public accounting firm of national reputation (a copy of which opinion must be furnished to the rating agency then providing the rating borne by the Series 2011 Bonds, if any), the availability of sufficient moneys to make such payment, and (b) all necessary and proper fees, compensation and expenses of the Bond Trustee and the Issuer pertaining to the Series 2011 Bonds with respect to which such deposit is made, have been paid or the payment thereof provided for to the satisfaction of the Bond Trustee. At such time as a Series 2011 Bond is deemed to be paid under the 2011 Bond Indenture, as aforesaid, such Series 2011 Bond will no longer be secured by or entitled to the benefits of the 2011 Bond Indenture, except for the purposes of any such payment from such moneys or Government Obligations.

Notwithstanding the foregoing, no deposit described in clause (a)(ii) of the immediately preceding paragraph will be deemed payment of such Series 2011 Bonds as aforesaid until (a) proper notice of redemption of such Series 2011 Bonds has been previously given in accordance with the 2011 Bond Indenture, or if said Series 2011 Bonds are not by their terms subject to redemption within the next 60 days, until the Corporation has given the Bond Trustee, in form satisfactory to the Bond Trustee, irrevocable instructions to notify, as soon as practicable, the Owners of the Series 2011 Bonds that the deposit described in such clause (a)(ii) above has been made with the Bond Trustee and that said Series 2011 Bonds are deemed to have been paid in accordance with the 2011 Bond Indenture and stating the maturity or redemption date upon which moneys are to be available for the payment of the principal of and the applicable redemption premium, if any, on said Series 2011 Bonds, plus interest thereon to the due date thereof; or (b) the maturity of such Series 2011 Bonds.

Before accepting or using any moneys to be deposited as described herein, the Bond Trustee may require that the Corporation furnish to it (i) an opinion of Bond Counsel to the effect that such deposit will not adversely affect the exclusion from gross income for federal income tax purposes of interest on the Series 2011 Bonds and that all conditions of the 2011 Bond Indenture described herein have been satisfied, and (ii) a certificate of an independent certified public accountant to the effect that such deposit will be sufficient to defease the Series 2011 Bonds as provided in the 2011 Bond Indenture. The Bond Trustee will be fully protected in relying upon such Bond Counsel opinion and/or accountant's certificate in accepting or using any moneys deposited as described herein.

All moneys so deposited with the Bond Trustee may also be invested and reinvested, at the written direction of the Corporation, in noncallable Government Obligations, maturing in the amounts and times as hereinbefore set forth, and all income from all Government Obligations in the hands of the Bond Trustee as described herein which is not required for the payment of the Series 2011 Bonds and interest and premium, if any, thereon with respect to which such moneys have been so deposited will be deposited in the Bond Fund as and when realized and collected for use and application as are other moneys deposited in the Bond Fund; provided that unless the opinion of Bond Counsel specifically permits any such reinvestment, the Corporation will furnish to the Bond Trustee an opinion of Bond Counsel to the effect that such reinvestment will not adversely affect the exclusion from gross income for federal income tax purposes of interest on the Series 2011 Bonds.

The Issuer has covenanted in the 2011 Bond Indenture that no deposit will knowingly be made or accepted and no use knowingly made of any such deposit which would cause the Series 2011 Bonds to be treated as arbitrage bonds within the meaning of Section 148 of the Code.

Notwithstanding any provision of any other article of the 2011 Bond Indenture which may be contrary to the provisions described herein, all moneys or Government Obligations so set aside and held in trust for the payment of Series 2011 Bonds (including interest and premium thereon, if any) will be applied to and used solely for the payment of the particular Series 2011 Bonds (including the interest and premium thereon, if any) with respect to which such moneys or Government Obligations have been so set aside in trust.

Defaults and Remedies

Defaults. The occurrence of any of the following events constitutes a "Default" under the 2011 Bond Indenture:

(a) Default in the due and punctual payment of interest on any Series 2011 Bond;

(b) Default in the due and punctual payment of the principal of or premium, if any, on any Series 2011 Bond, whether at the stated maturity thereof, or upon proceedings for redemption thereof, or upon the maturity thereof by declaration;

(c) The occurrence of a Default under the Loan Agreement;

(d) An event of default as described in subparagraph (a) under "Summary of Certain Provisions of the Master Indenture - Defaults and Remedies" above occurs and is continuing from and after the date on which the Master Trustee is entitled under the Master Indenture to declare any Obligation immediately due and payable, or the Master Trustee declares any Obligation immediately due and payable; and

(e) Default in the performance or observance of any other of the covenants, agreements or conditions on the part of the Issuer contained in the 2011 Bond Indenture or in the Series 2011 Bonds contained and failure to remedy the same after notice thereof pursuant to the provisions of the 2011 Bond Indenture.

Acceleration. Upon the occurrence of any Default, the Bond Trustee may, and at the written request of the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds must, by notice in writing delivered to the Issuer and the Corporation (or, if the Book Entry System is in effect, the Securities Depository), declare the principal of all Series 2011 Bonds and the interest accrued thereon to the date of such acceleration immediately due and payable. Upon any declaration of acceleration as described herein, the Bond Trustee will immediately declare all payments required to be made by the Corporation under the Loan Agreement to be immediately due and payable. Interest will cease to accrue on the Series 2011 Bonds on the date of declaration of acceleration as so described.

Other Remedies; Rights of Owners of Bonds. Subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above and with respect to indemnification of the Bond Trustee, upon the occurrence of a Default, the Bond Trustee may pursue any available remedy at law or in equity to enforce the payment of the principal of, premium, if any, and interest on the Outstanding Series 2011 Bonds.

Subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above, if a Default has occurred and is continuing and if requested so to do by the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds and provided the Bond Trustee is indemnified as provided in the 2011 Bond Indenture, the Bond Trustee will be obligated to exercise such one or more of the rights and powers conferred by the 2011 Bond Indenture, as the Bond Trustee, being advised by counsel, deems most expedient in the interests of the Owners of Series 2011 Bonds.

Subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above, no remedy by the terms of the 2011 Bond Indenture conferred upon or reserved to the Bond Trustee (or to the Owners of Series 2011 Bonds) is intended to be exclusive of any other remedy, but each and every such remedy will be cumulative and in addition to any other remedy given to the Bond Trustee or to the Owners of Series 2011 Bonds under the 2011 Bond Indenture or now or hereafter existing at law or in equity.

No delay or omission to exercise any right or power accruing upon any Default will impair any such right or power or be construed to be a waiver of any such Default or acquiescence therein; such right or power may be exercised from time to time as often as may be deemed expedient.

No waiver of any Default under the 2011 Bond Indenture, whether by the Bond Trustee or by the Owners of Series 2011 Bonds, will extend to or affect any subsequent Default or impair any rights or remedies consequent thereon.

Right of Owners of Series 2011 Bonds to Direct Proceedings. Subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above, anything in the 2011 Bond Indenture to the contrary notwithstanding, the Owners of at least a majority in aggregate principal amount of the Outstanding Series 2011 Bonds will have the right, at any time, by an instrument or instruments in writing executed and delivered to the Bond Trustee, to direct the method and place of conducting all proceedings to be taken in connection with the enforcement of the terms and conditions of the 2011 Bond Indenture, or for the appointment of a receiver or any other proceedings thereunder provided that such direction may not be otherwise than in accordance with the provisions of law and of the 2011 Bond Indenture.

Appointment of Receivers. Upon the occurrence of a Default, and upon the filing of a suit or other commencement of judicial proceedings to enforce the rights of the Bond Trustee and of the Owners of Series 2011 Bonds under the 2011 Bond Indenture, the Bond Trustee will be entitled, as a matter of right, to the appointment of a receiver or receivers of the Trust Estate and of the revenues, earnings, income, products and profits thereof, pending such proceedings, with such powers as the court making such appointment confers.

Waiver. Upon the occurrence of a Default, to the extent that such rights may then lawfully be waived, neither the Issuer nor anyone claiming through or under it, will set up, claim or seek to take advantage of any appraisement, valuation, stay, extension or redemption laws of any jurisdiction now or hereafter in force, in order to prevent or hinder the enforcement of the 2011 Bond Indenture, and the Issuer, for itself and all who may claim through or under it, has waived, to the extent that it lawfully may do so, the benefit of all such laws.

Application of Moneys. All moneys received by the Bond Trustee pursuant to any right given or action taken under the provisions of the 2011 Bond Indenture (other than moneys deposited with the Bond Trustee and held in accordance with the provisions of the 2011 Bond Indenture as described under "- Revenues and Funds - Nonpresentment of Bonds" above) will, after payment of the costs and expenses of the proceedings resulting in the collection of such moneys and of the fees, expenses, liabilities and advances owing to or incurred or made by the Bond Trustee and the creation of a reasonable reserve for anticipated fees, costs and expenses, be deposited in the Bond Fund and applied as follows:

(a) Unless the principal of all the Series 2011 Bonds has become or has been declared due and payable, all such moneys will be applied:

FIRST – To the payment to the persons entitled thereto of all installments of interest then due on the Series 2011 Bonds, in the order of the maturity of the installments of such interest (with interest on overdue installments of such interest, to the extent permitted by law, at the rate of interest borne by the Series 2011 Bonds) and, if the amount available are not sufficient to pay in full any particular installment, then to the payment ratably, according to the amounts due on such installment, to the persons entitled thereto, without any discrimination or privilege; and

SECOND – To the payment to the persons entitled thereto of the unpaid principal of and premium, if any, on any of the Series 2011 Bonds which have become due (other than Series 2011 Bonds matured or called for redemption for the payment of which moneys are held pursuant to the

provisions of the 2011 Bond Indenture), (with interest on overdue installments of principal and premium, if any, to the extent permitted by law, at the rate of interest borne by the Series 2011 Bonds) and, if the amount available are not sufficient to pay in full all Series 2011 Bonds due on any particular date, then to the payment ratably according to the amount of principal due on such date, to the persons entitled thereto without any discrimination or privilege; and

THIRD – To the payment to the persons entitled thereto as the same become due of the principal of and premium, if any, and interest on the Series 2011 Bonds which may thereafter become due and, if the amount available are not sufficient to pay in full Series 2011 Bonds due on any particular date, together with interest and premium, if any, then due and owing thereon, payment will be made ratably according to the amount of interest, principal and premium, if any, due on such date to the persons entitled thereto without any discrimination or privilege.

(b) If the principal of all the Series 2011 Bonds has become due or has been declared due and payable, all such moneys will be applied to the payment of the principal and interest then due and unpaid upon the Series 2011 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 Series 2011 Bond over any other Series 2011 Bond, ratably, according to the amounts due, respectively, for principal and interest, to the persons entitled thereto without any discrimination or privilege, with interest on overdue installments of interest or principal, to the extent permitted by law, at the rate of interest borne by the Series 2011 Bonds.

(c) If the principal of all the Series 2011 Bonds has been declared due and payable and if such declaration thereafter has been rescinded and annulled as provided in the 2011 Bond Indenture, then, subject to the provisions of the 2011 Bond Indenture described in subparagraph (b) above, if the principal of all the Series 2011 Bonds later becomes due or be declared due and payable, the moneys will be applied in accordance with the provisions of the 2011 Bond Indenture described in subparagraph (a) above.

Whenever moneys are to be applied as described herein, such moneys will be applied at such times, and from time to time, as the Bond Trustee determines, 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 applies such funds, it will fix the date (which must be an Interest Payment Date unless it deems another date more suitable) upon which such application is to be made and upon such date interest on the amounts of principal to be paid on such dates will cease to accrue; provided that upon an acceleration of Series 2011 Bonds as described under "- Acceleration" above, interest will cease to accrue on the Series 2011 Bonds on and after the date of such acceleration. The Bond Trustee will give such notice as it may deem appropriate of the deposit with it of any such moneys and of the fixing of any such date, and will not be required to make payment to the Owner of any Series 2011 Bond until such Series 2011 Bond is presented to the Bond Trustee for appropriate endorsement or for cancellation if fully paid.

Whenever the principal of, premium, if any, and interest on all Series 2011 Bonds have been paid as provided in the 2011 Bond Indenture and all expenses and charges of the Bond Trustee have been paid, any balance remaining in the Bond Fund will be paid to the Corporation as described under "- Revenues and Funds --Bond Fund" above.

Rights and Remedies of Owners of Bonds. No Owner of any Series 2011 Bond will have any right to institute any suit, action or proceeding at law or in equity for the enforcement of the 2011 Bond Indenture or for the execution of any trust thereof or for the appointment of a receiver or any other remedy thereunder, unless (subject to the provisions of the 2011 Bond Indenture described under "- Acceleration" above) (i) a Default has occurred of which the Bond Trustee has been notified as provided in the 2011 Bond Indenture, or of which it is deemed to have notice, (ii) the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds have made written request to the Bond Trustee and have offered it reasonable opportunity either to proceed to exercise the powers granted by the 2011 Bond Indenture or to institute such action, suit or proceeding and have offered to the Bond Trustee indemnity as provided in the 2011 Bond Indenture, and (iii) the Bond Trustee thereafter fails or refuses to exercise the powers granted by the 2011 Bond Indenture, or to institute such action, suit or proceeding. Such notification, request and offer of indemnity are in every case at the option of the Bond Trustee conditions

precedent to the execution of the powers and trusts of the 2011 Bond Indenture, and to any action or cause of action for the enforcement of the 2011 Bond Indenture, or for the appointment of a receiver or for any other remedy thereunder; it being understood and intended that no one or more Owners of the Series 2011 Bonds have any right in any manner whatsoever to affect, disturb or prejudice the lien of the 2011 Bond Indenture by their action or to enforce any right thereunder except in the manner provided therein, and that all proceedings at law or equity must be instituted, had and maintained in the manner therein provided and for the equal and ratable benefit of the Owners of all Outstanding Series 2011 Bonds. However, nothing contained in the 2011 Bond Indenture will affect or impair the right of any Owner of Series 2011 Bonds to enforce the payment of the principal of, premium, if any, and interest on any Series 2011 Bond at and after the maturity thereof, or the obligation of the Issuer to pay the principal of, premium, if any, and interest on each of the Series 2011 Bonds issued under the 2011 Bond Indenture to the respective Owners thereof at the time and place, from the source and in the manner in the Series 2011 Bonds expressed.

Waivers of Default. The Bond Trustee will waive any Default under the 2011 Bond Indenture and its consequences and rescind any declaration of acceleration of principal upon the written request of the Owners of (1) at least a majority in aggregate principal amount of all Outstanding Series 2011 Bonds in respect of which default in the payment of principal or interest, or both, exists or (2) at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds in the case of any other Default; provided that there may not be waived any Default as described in subparagraphs (a) or (b) under "- Defaults" above unless prior to such waiver or rescission, the Corporation has caused to be paid to the Bond Trustee (i) all arrears of principal and interest (other than principal of or interest on the Series 2011 Bonds which became due and payable by declaration of acceleration), with interest at the rate then borne by the Series 2011 Bonds on overdue installments, to the extent permitted by law, and (ii) all fees and expenses of the Bond Trustee in connection with such Default. In case of any waiver or rescission described above, or in case any proceeding taken by the Bond Trustee on account of any such Default has been discontinued or concluded or determined adversely, then and in every such case the Issuer, the Bond Trustee and the Owners of Series 2011 Bonds will be restored to their former positions and rights under the 2011 Bond Indenture, respectively, but no such waiver or rescission will extend to any subsequent or other Default, or impair any right consequent thereon.

Notice of Certain Defaults; Opportunity to Cure Such Defaults. Anything in the 2011 Bond Indenture to the contrary notwithstanding, no Default under the 2011 Bond Indenture as described in subparagraphs (c) or (d) under "- Defaults" above will be deemed a Default until notice of such Default has been given to the Issuer and the Corporation by the Bond Trustee or by the Owners of at least a majority in aggregate principal amount of all Outstanding Series 2011 Bonds, and the Issuer and the Corporation have had 30 days after receipt of such notice to correct said Default or to cause said Default to be corrected and have not corrected said Default or caused said Default to be corrected within the applicable period; provided that if said Default is such that it cannot be corrected within the applicable period, it will not constitute a Default if corrective action is instituted by the Issuer or the Corporation within the applicable period and diligently pursued until the Default is corrected.

With regard to any Default concerning which notice is given to the Issuer and the Corporation as described above, the Issuer has granted the Corporation full authority for the account of the Issuer to perform any covenant or obligation alleged in said notice to constitute a Default, in the name and stead of the Issuer with full power to do any and all things and acts to the same extent that the Issuer could do and perform any such things and acts and with power of substitution.

Bond Trustee

Acceptance of Trusts. The Bond Trustee has accepted the trusts imposed upon it by the 2011 Bond Indenture, and has agreed to perform said trusts, but only upon and subject to the terms and conditions set forth in the 2011 Bond Indenture.

Notice to Owners of Bonds if Default Occurs. If a Default occurs of which the Bond Trustee has been notified or of which it is deemed to have notice, as provided in the 2011 Bond Indenture, then the Bond Trustee will promptly give notice thereof to the Owner of each Series 2011 Bond.

Successor Bond Trustee. Any corporation or association into which the Bond Trustee may be converted or merged, or with which it may be consolidated, or to which it may sell or transfer its corporate trust business and assets as a whole or substantially as a whole, or any corporation or association resulting from any such conversion, sale, merger, consolidation or transfer to which it is a party, will be and become successor Bond Trustee under the 2011 Bond Indenture and vested with all of the title to the Trust Estate and all the trusts, powers, discretions, immunities, privileges and all other matters as was its predecessor, without the execution or filing of any instrument or any further act, deed or conveyance on the part of any of the parties to the 2011 Bond Indenture, anything therein to the contrary notwithstanding.

Resignation by the Bond Trustee. The Bond Trustee and any successor Bond Trustee may at any time resign from the trusts created by the 2011 Bond Indenture by giving 30 days' notice to the Issuer, the Corporation, and the Owner of each Series 2011 Bond. Such resignation will not take effect until the appointment of a successor Bond Trustee or temporary Bond Trustee. Upon such resignation, the resigning Bond Trustee shall be entitled to prompt payment in full of all fees and expenses and other amounts payable to the Bond Trustee pursuant to the 2011 Bond Indenture or the Loan Agreement.

Removal of the Bond Trustee. The Bond Trustee may be removed at any time by an instrument or concurrent instruments in writing delivered to the Bond Trustee and to the Issuer and signed by the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds. Such removal will not take effect until (i) the appointment of a successor Bond Trustee or temporary Bond Trustee and the transfer to said successor or temporary Bond Trustee of the Credit Facility and (ii) payment in full of all fees and expenses and other amounts payable to the Bond Trustee pursuant thereto or to the Loan Agreement.

Appointment of Successor Bond Trustee by Owners of Bonds. If the Bond Trustee resigns or is removed, or is dissolved, or is in the course of dissolution or liquidation, or otherwise becomes incapable of acting under the 2011 Bond Indenture, or if it is taken under the control of any public officer or officers, or of a receiver appointed by a court, a successor may be appointed by the Owners of at least a majority in aggregate principal amount of Outstanding Series 2011 Bonds by an instrument or concurrent instruments in writing signed by such Owners, or by their attorneys in fact duly authorized, a copy of which will be delivered personally or sent by registered mail to the Issuer and the Corporation. In case of any such vacancy, the Issuer, by an instrument executed by its official who executed the Series 2011 Bonds or his successor in office, may appoint a temporary successor Bond Trustee to fill such vacancy until a successor Bond Trustee may be appointed by the Owners of Series 2011 Bonds in the manner above described; and such temporary successor Bond Trustee so appointed by the Issuer will immediately and without further act be superseded by the Bond Trustee appointed by the Owners of Series 2011 Bonds. If no successor Bond Trustee has accepted appointment in the manner described in the immediately following paragraph within 60 days after the Bond Trustee has given notice of resignation to the Issuer and the Owner of each Series 2011 Bond, the Bond Trustee may petition any court of competent jurisdiction for the appointment of a temporary successor Bond Trustee; provided that any Bond Trustee so appointed will immediately and without further act be superseded by a Bond Trustee appointed by the Issuer or the Owners of Series 2011 Bonds as described herein. Every successor Bond Trustee appointed pursuant to the provisions of the 2011 Bond Indenture described herein, if there be such an institution willing, must be qualified and able to accept the trust upon customary terms, a bank or trust company within or without the State, in good standing and having reported capital and surplus of not less than $50,000,000 and rated Baa3/Prime-3 or better by Moody's (or a substantially equivalent rating by such other rating agency then providing the rating borne by the Series 2011 Bonds).

Acceptance by Successor Bond Trustee. Every successor Bond Trustee appointed under the 2011 Bond Indenture will execute, acknowledge and deliver to its or his predecessor and also to the Issuer and the Corporation an instrument in writing accepting such appointment and thereupon such successor, without any further act, deed or conveyance, will become fully vested with all the estates, properties, rights, powers, trusts, duties and obligations of its predecessor; but its predecessor will, nevertheless, on the written request of the Issuer, or of its successor, execute and deliver an instrument transferring to such successor all the estates, properties, rights, powers and trusts of such predecessor under the 2011 Bond Indenture; and every predecessor Bond Trustee will deliver all securities and moneys held by it as Bond Trustee under the 2011 Bond Indenture to its successor. Should any instrument in writing from the Issuer be required by any successor Bond Trustee for more fully and certainly vesting in such successor the estate, rights, powers and duties vested by the 2011 Bond Indenture or intended to be vested in the

predecessor, any and all such instruments in writing will, on request, be executed, acknowledged and delivered by the Issuer.

Supplemental Indentures

Supplemental Indentures Not Requiring Consent of Owners of Bonds. The Issuer and the Bond Trustee may, upon receipt of an opinion of Bond Counsel to the effect that the proposed supplemental indenture will not adversely affect the excludability of interest on the Series 2011 Bonds from gross income for federal income tax purposes and is authorized by the 2011 Bond Indenture, and without consent of, or notice to, any of the Owners of Series 2011 Bonds, enter into an indenture or indentures supplemental to the 2011 Bond Indenture for any one or more of the following purposes:

(a) To cure any ambiguity or formal defect or omission in the 2011 Bond Indenture;

(b) To grant to or confer upon the Bond Trustee for the benefit of the Owners of Series 2011 Bonds any additional rights, remedies, powers or authorities that may lawfully be granted to or conferred upon the Owners of Series 2011 Bonds or the Bond Trustee;

(c) To subject to the 2011 Bond Indenture additional revenues, properties or collateral;

(d) To modify, amend or supplement the 2011 Bond Indenture or any indenture supplemental thereof in such manner as to permit the qualification thereof under the Trust Indenture Act of 1939, as amended, or any similar federal statute hereafter in effect or to permit the qualification of the Series 2011 Bonds for sale under the securities laws of any of the states of the United States of America;

(e) To evidence the appointment of a separate or Co-Bond Trustee or the succession of a new Bond Trustee;

(f) To correct any description of, or to reflect changes in, any of the properties comprising the Trust Estate;

(g) To make any revisions of the 2011 Bond Indenture required by Fitch, Moody's or S&P in order to obtain or maintain an investment grade rating on the Series 2011 Bonds;

(h) To provide for an uncertificated system of registering the Series 2011 Bonds or to provide for changes to or from the Book Entry System; or

(i) To effect any other change in the 2011 Bond Indenture which is not to the material prejudice of the Bond Trustee or the Owners of Series 2011 Bonds.

If Fitch, S&P and/or Moody's, as the case may be, has issued a rating of any of the Series 2011 Bonds, the Bond Trustee will provide written notice of the proposed amendment to such rating agencies, but such notice will not be a condition of the effectiveness of such amendment.

Supplemental Indentures Requiring Consent of Owners of Bonds. Exclusive of supplemental indentures described under "- Supplemental Indentures Not Requiring Consent of Owners of Bonds" above, and subject to the terms and provisions contained in the 2011 Bond Indenture and not otherwise, the Owners of not less than a majority in aggregate principal amount of the Outstanding Series 2011 Bonds have the right, from time to time, anything contained in the 2011 Bond Indenture to the contrary notwithstanding, to consent to and approve the execution by the Issuer and the Bond Trustee of such other indenture or indentures supplemental to the 2011 Bond Indenture as deemed necessary and desirable for the purpose of modifying, altering, amending, adding to or rescinding, in any particular, any of the terms or provisions contained in the 2011 Bond Indenture or in any supplemental indenture; provided that nothing contained in the 2011 Bond Indenture will permit, or be construed as permitting, without the consent of the Owners of all Series 2011 Bonds Outstanding, (a) an extension of the maturity

of the principal of, or the interest on, any bond issued under the 2011 Bond Indenture, or (b) a reduction in the principal amount of, or redemption premium on, any Series 2011 Bond or the rate of interest thereon, or (c) a privilege or priority of any Series 2011 Bond or Series 2011 Bonds over any other Series 2011 Bond or Series 2011 Bonds, or (d) a reduction in the aggregate principal amount of the Series 2011 Bonds required for consent to such supplemental indentures or any modifications or waivers of the provisions of the 2011 Bond Indenture or the Loan Agreement, or (e) the creation of any lien ranking prior to or on a parity with the lien of the 2011 Bond Indenture on the Trust Estate or any part thereof, except as hereinbefore expressly described, or (f) the deprivation of the Owner of any Outstanding Series 2011 Bond of the lien created by the 2011 Bond Indenture on the Trust Estate.

If at any time the Issuer requests the Bond Trustee to enter into any such supplemental indenture for any of the purposes described in the preceding paragraph, the Bond Trustee will, upon being satisfactorily indemnified with respect to expenses, cause notice of the proposed execution of such supplemental indenture to be given to the Owners of the Series 2011 Bonds as provided in the 2011 Bond Indenture; provided that prior to the delivery of such notice, the Bond Trustee may require that an opinion of Bond Counsel be furnished to the effect that the supplemental indenture complies with the provisions of the 2011 Bond Indenture and will not adversely affect the excludability of interest on the Series 2011 Bonds from gross income for federal income tax purposes. Such notice will briefly set forth the nature of the proposed supplemental indenture and state that copies thereof are on file at the Principal Office of the Bond Trustee for inspection by all Owners of Series 2011 Bonds. If, within 60 days or such longer period as prescribed by the Issuer following such notice, the Owners of not less than a majority in aggregate principal amount of the Series 2011 Bonds Outstanding (except for those supplemental indentures requiring the consent of the Owners of all Series 2011 Bonds Outstanding as described above) at the time of the execution of any such supplemental indenture have consented to and approved the execution thereof as described herein, no Owner of any Series 2011 Bond will have any right to object to any of the terms and provisions contained therein, or the operation thereof, or in any manner to question the propriety of the execution thereof, or to enjoin or restrain the Bond Trustee or the Issuer from executing the same or from taking any action pursuant to the provisions thereof. Upon the execution of any such supplemental indenture as permitted by the 2011 Bond Indenture, the 2011 Bond Indenture will be and be deemed to be modified and amended in accordance therewith.

If Fitch, S&P and/or Moody's, as the case may be, has issued a rating of any of the Series 2011 Bonds, the Bond Trustee will provide written notice of the proposed amendment to such rating agencies, but such notice will not be a condition of the effectiveness of such amendment.

Consent of the Corporation. Anything in the 2011 Bond Indenture to the contrary notwithstanding, a supplemental indenture as described above will not become effective unless and until the Corporation has consented to the execution and delivery of such supplemental indenture. In this regard, the Bond Trustee will cause notice of the proposed execution of any such supplemental indenture, together with a copy of the proposed supplemental indenture, to be mailed to the Corporation at least 15 Business Days prior to the proposed date of execution and delivery of any such supplemental indenture.

Amendment without Consent of Issuer. If the Issuer is unable to enter into any supplemental indenture permitted by the 2011 Bond Indenture as described above, the Bond Trustee may, without the consent of the Issuer, amend or supplement the 2011 Bond Indenture in any manner otherwise permitted by the 2011 Bond Indenture so long as such supplemental indenture does not adversely affect the rights of the Issuer.

Execution of Amendments and Supplements by Bond Trustee. The Bond Trustee will not be obligated to sign any amendment or supplement to the 2011 Bond Indenture or the Series 2011 Bonds if the amendment or supplement, in the judgment of the Bond Trustee, could adversely affect the rights, duties, liabilities, protections, privileges, indemnities or immunities of the Bond Trustee. In signing an amendment or supplement, the Bond Trustee will be entitled to receive, and to be fully protected in conclusively relying on, an opinion of Bond Counsel stating that such amendment or supplement is authorized by the 2011 Bond Indenture, and will not adversely affect the exclusion of interest on the Series 2011 Bonds from gross income for federal income tax purposes.

Amendment of Loan Agreement

Amendments to Loan Agreement Not Requiring Consent of Owners of Bonds. The Issuer and the Bond Trustee may, upon receipt of an opinion of Bond Counsel to the effect that the proposed amendment will not adversely affect the excludability of interest on the Series 2011 Bonds from gross income for federal income tax purposes and is authorized by the 2011 Bond Indenture, and without the consent of or notice to the Owners of Series 2011 Bonds, consent to any amendment, change or modification of the Loan Agreement as may be required (i) by the provisions of the Loan Agreement, (ii) for the purpose of curing any ambiguity or formal defect or omission in the Loan Agreement, (iii) to enter into an indenture or indentures supplemental to the 2011 Bond Indenture as described under "- Supplemental Indentures - Supplemental Indentures Not Requiring Consent of Owners of Bonds" above; (iv) to make any revisions required by Fitch, Moody's and/or S&P in order to obtain or maintain an investment grade rating on the Series 2011 Bonds, (v) in connection with any other change therein which is not to the prejudice of the Bond Trustee or the Owners of Series 2011 Bonds or (vi) to make revisions thereto which will be effective only upon, and in connection with, the remarketing of all of the Series 2011 Bonds then Outstanding.

Amendments to Loan Agreement Requiring Consent of Owners of Bonds. Except for amendments, changes or modifications as described in the immediately preceding paragraph, neither the Issuer nor the Bond Trustee may consent to any other amendment, change or modification of the Loan Agreement without mailing of notice and the written approval or consent of the Owners of a majority in aggregate principal amount of the Outstanding Series 2011 Bonds, provided that the consent of the Owners of all Series 2011 Bonds Outstanding is required for any amendment, change or modification of the Loan Agreement that would permit the termination or cancellation of the Loan Agreement or a reduction in or postponement of the payments under the Loan Agreement or any change in the provisions relating to payment thereunder. If at any time the Issuer and the Corporation request the consent of the Bond Trustee to any such proposed amendment, change or modification of the Loan Agreement, the Bond Trustee, upon being satisfactorily indemnified with respect to expenses, will cause notice of such proposed amendment, change or modification to be given as provided in the 2011 Bond Indenture; provided that prior to the delivery of such notice or request, the Bond Trustee and the Issuer may require that an opinion of Bond Counsel be furnished to the effect that such amendment, change or modification complies with the provisions of the 2011 Bond Indenture and will not adversely affect the excludability of interest on the Series 2011 Bonds from gross income for federal income tax purposes.

The Bond Trustee will not be obligated to sign any amendment or supplement to the Loan Agreement if such amendment or supplement, in the judgment of the Bond Trustee, might adversely affect the rights, duties, liabilities, protections, indemnities or immunities of the Bond Trustee. In signing any such amendment or supplement, the Bond Trustee will be entitled to receive, and will be fully protected in conclusively relying upon, an opinion of Bond Counsel stating that such amendment or supplement is authorized by the 2011 Bond Indenture and will not impair the exclusion of the interest on any Series 2011 Bonds from the gross income of the Owners thereof for federal income tax purposes.

Payments Due on Saturdays, Sundays and Holidays

In any case where the date of maturity of interest on or principal of the Series 2011 Bonds or the date fixed for purchase or redemption of any Series 2011 Bonds is not be Business Day, then payment of principal, premium, if any, or interest need not be made on such date but may be made on the next Business Day with the same force and effect as if made on the date of maturity or the date fixed for purchase or redemption.

No Personal Liability

Notwithstanding anything to the contrary contained in the 2011 Bond Indenture or in any of the Series 2011 Bonds or the Loan Agreement, or in any other instrument or document executed by or on behalf of the Issuer in connection therewith, no stipulation, covenant, agreement or obligation contained therein may be deemed or construed to be a stipulation, covenant, agreement or obligation of any present or future member, commissioner, director, trustee, officer, employee or agent of the Issuer, or of any incorporator, member, commissioner, director,

trustee, officer, employee or agent of any successor to the Issuer, in any such person's individual capacity, and no such person, in his individual capacity, will be liable personally for any breach or non observance of or for any failure to perform, fulfill or comply with any such stipulations, covenants, agreements or obligations, nor may any recourse be had for the payment of the principal of, premium, if any, or interest on any of the Series 2011 Bonds or for any claim based thereon or on any such stipulation, covenant, agreement or obligation, against any such person, in his individual capacity, either directly or through the Issuer or any successor to the Issuer, under any rule of law or equity, statute or constitution or by the enforcement of any assessment or penalty or otherwise, and all such liability of any such person, in his individual capacity, has been expressly waived and released in the 2011 Bond Indenture.

SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT

The following is a summary of certain provisions of the Loan Agreement between the Corporation and the Issuer, to which reference is made for a full and complete statement of its provisions.

Loan of Series 2011 Bond Proceeds

Pursuant to the Loan Agreement, the Issuer will lend the proceeds from the sale of the Series 2011 Bonds to the Corporation. The Series 2011 Obligation will be delivered to the Issuer and assigned to the Bond Trustee to evidence such loan and the obligation of the Obligated Group to repay the same. The Series 2011 Obligation will be issued in a principal amount equal to the aggregate principal amount of the Series 2011 Bonds, and will provide for payment of principal, premium, if any, and interest thereon, sufficient to permit the Issuer to make payments of principal, premium, if any, and interest on the Series 2011 Bonds.

Payment of Series 2011 Bonds

The Corporation has agreed that the principal of, premium, if any, and interest on the Series 2011 Bonds will be payable in accordance with the provisions of the 2011 Bond Indenture and the Loan Agreement. The Corporation has further agreed that the Loan Agreement, the Series 2011 Obligation and any additional Obligation delivered to the Issuer to evidence loans made by the Issuer pursuant to the Loan Agreement from the proceeds of Additional Bonds and payments to be made thereunder and thereon (excluding Reserved Rights) will be assigned and pledged to the Bond Trustee to secure the payment of the Series 2011 Bonds. The foregoing notwithstanding, the Corporation has agreed that the moneys and securities, if any, on deposit in the Rebate Fund created under the 2011 Bond Indenture are not part of the Trust Estate and are not available to make payments of principal and interest on the Series 2011 Bonds.

Obligation Payments; Fund Deposits; Prepayments And Other Payments

Payment of Principal, Premium, if any, and Interest. The Corporation has covenanted that it will duly and punctually pay the principal of, premium, if any, and interest on the Series 2011 Bonds at the dates and the places and in the manner mentioned in the Series 2011 Bonds according to the true intent and meaning thereof.

Payments in Respect of the Series 2011 Obligation. The Corporation has covenanted and agreed to make the following payments in respect of the Series 2011 Obligation directly to the Bond Trustee for application under the 2011 Bond Indenture on the following dates:

(a) Interest: On or prior to each Interest Payment Date for the Series 2011 Bonds, an amount which is not less than the interest to become due on the next Interest Payment Date of the Series 2011 Bonds; provided that the Corporation will be entitled to certain credits on such payments as permitted by the Loan Agreement and described under "- Credits on Obligation" below.

(b) Principal: On or prior to each date on which principal of the Series 2011 Bonds is due and payable, an amount which is not less than the next installment of principal coming due on the Series 2011 Bonds by maturity or mandatory sinking fund redemption; provided that the Corporation will be entitled to certain credits on such payments as permitted by the Loan Agreement and described under "- Credits on Obligation" below.

Credits on Obligation. Notwithstanding any provision contained in the Loan Agreement or in the 2011 Bond Indenture to the contrary, in addition to any credits on the Series 2011 Obligation or any additional Obligation pledged under the 2011 Bond Indenture resulting from the payment or prepayment thereof from other sources:

(a) any moneys deposited by the Bond Trustee or the Corporation in the Bond Fund maintained under the 2011 Bond Indenture will be credited against the obligation of the Corporation to pay the principal of and interest on the Obligation pledged under the 2011 Bond Indenture as the same become due and in the order of maturity to the same extent as payments are applied upon the principal of and interest on, respectively, the Series 2011 Bonds through the Bond Fund; and

(b) the principal amount of Series 2011 Bonds of any series and maturity purchased by the Corporation and delivered to the Bond Trustee, or purchased by the Bond Trustee and cancelled, will be credited against the obligation of the Corporation to pay the principal of the Obligation (including installment payments corresponding to mandatory sinking fund payments on such Series 2011 Bonds) related to such series of Series 2011 Bonds so purchased; provided that deposit of a Series 2011 Bond of one maturity may not be credited against an Obligation which would be used, in the normal course, to retire a Series 2011 Bond of another maturity.

Additional Payments. The Corporation has agreed to pay directly all costs incurred by or on behalf of the Issuer or the Corporation in connection with or incident to the issuance and sale of the Series 2011 Bonds which exceed the amount on deposit in the Costs of Issuance Fund established under the 2011 Bond Indenture. The Corporation has also agreed to pay the following items to the following persons as additional payments under the Loan Agreement:

(a) To the Bond Trustee, within 30 days of receipt of written demand therefor, all reasonable fees and expenses of the Bond Trustee for services rendered under the 2011 Bond Indenture and all reasonable fees and charges of any Paying Agent, registrars, counsel, accountants, consultants, engineers and other persons incurred in the performance of services under the 2011 Bond Indenture, on request of the Bond Trustee for which the Bond Trustee and such other persons are entitled to payment or reimbursement;

(b) To the Issuer, upon demand, all fees and expenses incurred by the Issuer in relation to the Series 2011 Obligation pledged under the 2011 Bond Indenture or the Series 2011 Bonds which are not otherwise required to be paid by the Corporation under the terms of the Loan Agreement, and all fees, expenses, taxes and assessments of the Issuer as provided for under the Act; and

(c) To the Master Trustee or the Bond Trustee, as the case may be, the amount of all advances of funds made by either of them under the provisions of the Master Indenture or the 2011 Bond Indenture, with interest thereon from the date of each such advance at the lesser of (i) Master Trustee's or Bond Trustee's (or the Bond Trustee's affiliated bank's), as the case may be, announced prime rate per annum from time to time in effect or (ii) the highest amount then allowed by law.

(d) If the Corporation fails to make any of the payments required by the Loan Agreement as described herein, the item or installment so in default will continue as an obligation of the Corporation until the amount in default has been fully paid, and the Corporation has agreed to pay the same with interest thereon, to the extent permitted by law, from the date when such payment was due, at the rate of interest borne by the Series 2011 Bonds.

Obligation of Corporation Unconditional. The obligations of the Corporation to make the payments described above and to perform and observe the other agreements contained in the Loan Agreement are absolute and

unconditional will not be subject to any defense or any right of setoff, counterclaim or recoupment arising out of any breach by the Issuer or the Bond Trustee of any obligation to the Corporation, whether under the Loan Agreement or otherwise, or out of any indebtedness or liability at any time owing to the Corporation by the Issuer or the Bond Trustee, and, until such time as the principal of, premium, if any, and interest on the Series 2011 Bonds have been fully paid or provision for the payment thereof has been made in accordance with the 2011 Bond Indenture, the Corporation has agreed that it (i) will not suspend or discontinue any payments provided for in the Loan Agreement as described above, (ii) will perform and observe all other agreements contained in the Loan Agreement and (iii) except as otherwise provided in the Loan Agreement, will not terminate the Term of Agreement for any cause, including, without limiting the generality of the foregoing, any change in the tax or other laws of the United States of America or of the State or any political subdivision of either thereof or any failure of the Issuer or the Bond Trustee to perform and observe any agreement, whether express or implied, or any duty, liability or obligation arising out of or connected with the Loan Agreement. Nothing contained in the Loan Agreement as herein described will be construed to release the Issuer from the performance of any of the agreements on its part contained in the Loan Agreement, and if the Issuer or the Bond Trustee fails to perform any such agreement on its part, the Corporation may institute such action against the Issuer or the Bond Trustee as the Corporation deems necessary to compel performance so long as such action does not abrogate the obligations of the Corporation described in the first sentence of this paragraph.

Prepayment and Redemption

Prepayment Generally. The Corporation will have the option to prepay its obligations under the Loan Agreement at the times and in the amounts as necessary to exercise its option to cause the Series 2011 Bonds to be redeemed as set forth in the 2011 Bond Indenture and in the Series 2011 Bonds. If such prepayment is made, the Issuer agrees to accept prepayment of the Series 2011 Obligation pledged under the 2011 Bond Indenture to the extent required to provide for a permitted prepayment or redemption of the Series 2011 Bonds. No other prepayment of the Series 2011 Obligation pledged under the 2011 Bond Indenture will be permitted.

Amortization Schedules. On the date of any partial prepayment of any Obligation pledged under the 2011 Bond Indenture, the Corporation, upon consultation with the Bond Trustee, will deliver to the Issuer two copies of an amortization schedule with respect to the Series 2011 Obligation then outstanding setting forth the amount of the installments to be paid on the Series 2011 Obligation after the date of such partial prepayment and the unpaid principal balance of the Series 2011 Obligation after payment of each such installment.

Covenants Relating to Use and Operation of Corporation's Property

Use of the Corporation's Property. The Corporation will use its health care Facilities primarily as and for a general hospital and related activities and only in furtherance of the lawful corporate purposes of the Corporation.

The Corporation has agreed that it will not permit any of the Property for which it or the Issuer is or was reimbursed or which is or has been acquired, constructed or equipped, in whole or in part, out of (a) the loan of proceeds of the Series 2011 Bonds or (b) the proceeds of any loan refinanced or for the refinancing of which the Corporation or the Issuer is or has been reimbursed, in whole or in part, whether directly or indirectly, from the proceeds of the Series 2011 Bonds, to be used (i) by any Person in an Unrelated Trade or Business of the Corporation, or (ii) by any Person who is not a Tax-Exempt Organization, in either case in such manner or to such extent as would result in the loss of tax exemption of interest on the Series 2011 Bonds or the Series 2011 Bonds or any other such tax-exempt bonds otherwise afforded under Section 103(a) of the Code.

The Corporation has further agreed that it will not use or permit to be used any of the Property for which it is reimbursed or which is acquired, constructed or equipped, in whole or in part, out of (a) the loan of proceeds of the Prior Bonds or (b) the proceeds of any loans refinanced or for the refinancing of which the Corporation is reimbursed, in whole or in part, whether directly or indirectly, from the proceeds of the Series 2011 Bonds (i) primarily for sectarian instruction or study or as a place of devotional activities or religious worship or as a facility used primarily in connection with any part of the program of a school or department of divinity for any

religious denomination or the training of ministers, priests, rabbis or other similar persons in the field of religion, or (ii) in a manner which is prohibited by the Establishment of Religion Clause of the First Amendment to the Constitution of the United States of America and the decisions of the United States Supreme Court interpreting the same or by any comparable provisions of the Constitution of the State and the decisions in the Supreme Court of the State interpreting the same.

The Corporation will permit the Issuer and the Bond Trustee to make inspections of any of its Property to determine compliance with the provisions of the Loan Agreement described in the two preceding paragraphs. The provisions of the Loan Agreement described in this paragraph and the immediately preceding paragraph will remain in full force and effect notwithstanding the payment of the Series 2011 Bonds and the Series 2011 Obligation and the termination of the 2011 Bond Indenture and the Loan Agreement.

Rates and Charges. The Corporation has covenanted and agreed to operate its existing health care Facilities primarily as a revenue producing hospital or as facilities related thereto, and to operate all its Property on a nondiscriminatory basis, to charge such fees and rates for its Facilities and services and to exercise such skill and diligence as to provide income from its Property together with other available funds sufficient to pay promptly all expenses of operation, maintenance and repair of its Property, all amounts owing under the 2011 Bond Indenture and all other payments required to be made by the Corporation under the Loan Agreement to the extent permitted by law. The Corporation has further covenanted and agreed that it will, from time to time as often as necessary, 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 Loan Agreement described herein. The provisions of the Loan Agreement described in this paragraph may not be construed to prohibit the Corporation from serving indigent patients to the extent required for it to continue its qualification as a Tax-Exempt Organization or from serving any other class or classes of patients without charge at or reduced rates so long as such service does not prevent the Corporation from satisfying the other requirements of the Loan Agreement described herein.

Particular Corporation Covenants

Maintenance of Corporate Existence and Status. The Corporation has agreed that, except as permitted by the Master Indenture, it will at all times maintain its existence as a Tennessee nonprofit corporation and that it will neither take any action nor suffer any action to be taken by others which will alter, change or destroy its status as a nonprofit corporation or its status as a Tax-Exempt Organization. The Corporation has further covenanted and agreed that, as long as any Series 2011 Bonds remain Outstanding, it or any successor thereto into which it is merged or consolidated under the terms of the Master Indenture will remain a member of the Obligated Group. The Corporation has further agreed that it will not act or fail to act in any other manner which would adversely affect the exemptions from federal income tax of the interest earned by the owners of the Series 2011 Bonds to which such Series 2011 Bonds would otherwise be entitled.

Maintenance; Recording. The Corporation will, at its expense, take all necessary action to maintain and preserve the Loan Agreement so long as the Series 2011 Obligation or any additional Obligation pledged under the 2011 Bond Indenture is Outstanding. The Corporation will, forthwith after the execution and delivery of the Loan Agreement and thereafter from time to time, cause the Loan Agreement and all documents securing the Loan Agreement or any document securing the Series 2011 Obligation pledged under the 2011 Bond Indenture (including any amendments and supplements thereof) and any financing statements in respect thereof to be filed, registered and recorded in such manner and in such places as may be required by law in order to publish notice thereof and fully to perfect and protect the lien of the 2011 Bond Indenture upon the trust estate referred to therein or any part thereof and, from time to time, will perform or cause to be performed any other act as provided by law and will execute or cause to be executed any and all continuation statements and further instruments that may be requested by the Issuer or the Bond Trustee for such publication, perfection and protection. The Corporation will provide copies to the Bond Trustee of any such filings or registrations. Except to the extent it is exempt therefrom, the Corporation will pay or cause to be paid all filing and registration and recording fees incident to such filing and registration and recording, and all expenses incident to the preparation, execution and acknowledgment of such instruments of further assurance and all federal or state fees and other similar fees, duties, imposts, assessments and charges arising out of or in connection with the execution and delivery of the Loan Agreement, the Series 2011 Obligation and such instruments of further assurance.

Financial Statements. The Corporation has covenanted that it will keep proper books of records and accounts in which full, true and correct entries will be made of all dealings or transactions of, or in relation to, the business and affairs of the Corporation in accordance with generally accepted principles of accounting consistently applied and will furnish the materials and notice required to be delivered to the Master Trustee pursuant to the Master Indenture. In addition, the Corporation covenants that it will prepare unaudited consolidated financial statements, including balance sheets, income statements and cash flow for the three-month periods ending September 30, December 31 and March 31 of each year and will file the same with the Municipal Securities Rulemaking Board's Electronic Municipal Market Access system within 45 days following the end of each such three-month period.

Indemnity. The Corporation has agreed that it will pay, protect, indemnify and save the Issuer and the Bond Trustee harmless from and against any and all liabilities, losses, damages, costs and expenses (including reasonable attorneys' fees, costs and expenses of the Issuer and the Bond Trustee), causes of action, suits, claims, demands and judgments of whatsoever kind and nature (including those arising or resulting from any injury to or death of any person or damage to property) arising from or in any manner directly or indirectly growing out of or connected with the following:

(a) the use, non-use, condition or occupancy of any of the Corporation's Property, any repairs, construction, alterations, renovation, relocation, remodeling and equipping thereof or thereto or the condition of any of such Property including adjoining sidewalks, streets or alleys and any equipment or Facilities at any time located on such Property or used in connection therewith but which are not the result of the negligence of the Issuer or the Bond Trustee;

(b) violation of any agreement, warranty, covenant or condition of the Loan Agreement, except by the Issuer;

(c) violation of any contract, agreement, or restriction by the Corporation relating to its Property;

(d) violation of any law, ordinance, regulation or court order affecting any of the Corporation's Property or the ownership, occupancy or use thereof;

(e) any statement or information concerning the Corporation or any other Obligated Issuer, any of its or their officers and members or its or their Property, contained in any official statement furnished to the Issuer or the purchaser of any Series 2011 Bonds, that is untrue or incorrect in any material respect, and any omission from such official statement of any statement or information which should be contained therein for the purpose for which the same is to be used or which is necessary to make the statements therein concerning the Corporation or any other Obligated Issuer, any of its or their officers and members and its or their Property not misleading in any material respect, provided that such official statement has been approved by the Corporation or the Obligated Group Agent and the indemnified party did not have knowledge of the omission or misstatement or did not use such official statement with reckless disregard of or gross negligence in regard to the accuracy or completeness of such official statement; and

(f) the performance by the Bond Trustee of its duties under the 2011 Bond Indenture, but only to the extent that the Bond Trustee is not negligent in such performance.

For purposes of the provisions of the Loan Agreement described under "- Indemnity," Property will be deemed to include property otherwise excluded from the definition of "Property" as described in subparagraph (j) "Summary of Certain Provisions of the Master Indenture - Disposition of Property" above.

Such indemnity will extend to each person, if any, who "controls" the Issuer or the Bond Trustee, as the case may be, as that term is defined in Section 15 of the Securities Act of 1933, as amended, and to any officer, director or employee of the Issuer or the Bond Trustee.

In the event of settlement of any litigation commenced or threatened, such indemnity will be limited to the aggregate amount paid under a settlement effected with the written consent of the Corporation or the Obligated Group Agent.

The Issuer and the Bond Trustee will promptly notify the Corporation and the Obligated Group Agent in writing of any claim or action brought against the Issuer, the Bond Trustee or any controlling person, as the case may be, in respect of which indemnity may be sought against the Corporation, setting forth the particulars of such claim or action, and the Corporation will assume the defense thereof, including the employment of counsel satisfactory to the Issuer, the Bond Trustee or such controlling person, as the case may be, and the payment of all reasonable expenses. The Issuer, the Bond Trustee or any such controlling person, as the case may be, may employ separate counsel in any such action and participate in the defense thereof, but the fees and expenses of such counsel will not be payable by the Corporation unless such employment has been specifically authorized in writing by the Corporation.

All amounts payable to or with respect to the Issuer as herein described will be deemed to be fees and expenses of the Issuer for the purposes of the provisions of the Loan Agreement and of the 2011 Bond Indenture dealing with assignment of the Issuer's rights under the loan Agreement. The indemnification provided in the Loan Agreement shall survive the termination of the Loan Agreement, the payment in full of the Series 2011 Bonds or the sooner resignation or removal of the Bond Trustee and shall inure to the benefit of the Bond Trustee's successor and assigns.

Accreditation and Licensure. The Corporation has warranted that its hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations and that its health care Facilities have all state and local licenses required for the operation thereof. The Corporation has covenanted that it will obtain and maintain all such licenses required for its operations and the operation of its health care Facilities and will use its best efforts to obtain and maintain such accreditation, so long as it is in the best interests of the Corporation and the Bondholders.

Government Grants. The Corporation has covenanted to comply with all of the terms and provisions of any government grants it receives, including those made by the State and the federal government, and the laws and regulations under which they are made.

Transfer of Assets. The Corporation has covenanted and agreed that it will not sell, lease or otherwise dispose of any of its Property except as permitted by the Master Indenture. The provisions of the Master Indenture notwithstanding, the Corporation has further covenanted and agreed that it will not sell, lease or otherwise dispose (including without limitation any involuntary disposition) of in excess of 2% in the aggregate of the Property financed or refinanced with the proceeds of the Series 2011 Bonds (which percentage will be reduced to the extent Property financed or refinanced with the proceeds of the Series 2011 Bonds is being used in an Unrelated Trade or Business of the Corporation) unless (a) prior to such sale, lease or other disposition the Corporation delivers to the Bond Trustee and the Issuer a written Opinion of Bond Counsel (which counsel and opinion are acceptable to the Bond Trustee) to the effect that any such disposition will not adversely affect the validity of the Series 2011 Bonds or the exemption from federal income taxation of the interest paid on the Series 2011 Bonds or any other such tax-exempt bonds under Section 103(a) of the Code, or (b) prior to such sale, lease or other disposition there is delivered to the Bond Trustee an Officer's Certificate of the Corporation stating that, in the judgment of such officer, such Property has become inadequate, obsolete or worn out and that any amounts received by the Corporation upon such disposition must be applied by the Corporation to acquire additional Property constituting a "project" under the Act. The Corporation has agreed to apply the proceeds of any disposition referred to in a certificate of the type described in clause (b) above as described in such clause and has agreed that any property acquired with such proceeds will be deemed to be Property financed or refinanced with the proceeds of the Series 2011 Bonds for the purposes of applying the provisions of the Loan Agreement. The amount of Property disposed of will be calculated in accordance with the provisions of the Master Indenture.

The provisions of the Master Indenture notwithstanding, the Corporation has further covenanted and agreed that it will not sell, lease or otherwise dispose (including without limitation any involuntary disposition) of any Property pursuant to the provisions of the Master Indenture described in subparagraph (c) under "Summary of Certain Provisions of the Master Indenture - Disposition of Property" above unless, prior to the sale, lease or other disposition, the Corporation delivers to the Master Trustee and the Bond Trustee an Officer's Certificate certifying

that Property so transferred in the then-current Fiscal Year by all Obligated Issuers and Restricted Affiliates does not exceed the lesser of (i) 10% of the Value of all Property of the Combined Group for the immediately preceding Fiscal Year or (ii) 5% of the aggregate of "gross patient revenues" of each member of the Combined Group for the immediately preceding Fiscal Year.

The provisions of the Master Indenture notwithstanding, the Corporation has further covenanted and agreed that it will not sell, lease or otherwise dispose (including without limitation any involuntary disposition) of any Property pursuant to the provisions of the Master Indenture described under "Summary of Certain Provisions of the Master Indenture - Disposition of Property" above unless, prior to the sale, lease or other disposition, the Corporation delivers to the Master Trustee and the Bond Trustee an Officer's Certificate certifying that, after such sale, lease or other disposition, the Corporation will have Unrestricted Cash and Investments in an amount equal to at least 100 Days of Operating Expenses, calculated as of the end of the most recently audited fiscal year and as if the sale, lease or other disposition had occurred at the beginning of such fiscal year. For purposes of this paragraph, "Unrestricted Cash and Investments" means the sum of cash, cash equivalents and unrestricted/unencumbered long term marketable or liquid investments less trustee held funds, reserves, deposits or set asides including debt service funds, construction funds, reserve funds, malpractice funds, litigation reserves, self insurance or captive insurer funds, and pension or retirement funds, adjusted to exclude any short term indebtedness, and "100 Days of Operating Expenses" means operating expenses minus depreciation and amortization expense for the applicable fiscal year divided by 365 or 366, as appropriate, then multiplied by 100.

Maintenance of Status as a Member of the Obligated Group. The Corporation has covenanted and agreed that as long as any Series 2011 Bonds remain Outstanding, it will remain a member of the Obligated Group.

Defaults and Remedies

Defaults Defined. The following are "Defaults" under the Loan Agreement and the term "Default" means, whenever it is used in the Loan Agreement, any one or more of the following events:

(a) Failure by the Corporation to pay any amount required to be paid as described under "- Obligation Payments; Fund Deposits; Prepayments and Other Payments - Payments in Respect of the Series 2011 Obligation."

(b) Failure by the Corporation to observe and perform any covenant, condition or agreement on its part to be observed or performed, other than as described in subparagraph (a) above, for a period of 30 days after written notice specifying such failure and requesting that it be remedied has been given to the Corporation by the Issuer or the Bond Trustee, unless the Issuer and the Bond Trustee agree in writing to an extension of such time prior to its expiration; provided that if the failure stated in the notice cannot be corrected within the applicable period, the Issuer and the Bond Trustee will not unreasonably withhold their consent to an extension of such time if corrective action is instituted by the Corporation within the applicable period and diligently pursued until such failure is corrected.

(c) The dissolution or liquidation of the Corporation, except as authorized by the Loan Agreement or the Master Indenture, or the voluntary initiation by the Corporation of any proceeding under any federal or state law relating to bankruptcy, insolvency, arrangement, reorganization, readjustment of debt or any other form of debtor relief, or the initiation against the Corporation of any such proceeding which remain undismissed for 60 days, or failure by the Corporation to promptly have discharged any execution, garnishment or attachment of such consequence as would impair the ability of the Corporation to carry on its operations at the Facilities, or assignment by the Corporation for the benefit of creditors, or the entry by the Corporation into an agreement of composition with its creditors or the failure generally by the Corporation to pay its debts as they become due.

(d) The occurrence of a Default under the 2011 Bond Indenture.

The provisions of the Loan Agreement described in subparagraph (b) above are subject to the following limitation: if by reason of force majeure the Corporation is unable in whole or in part to carry out any of its agreements contained herein (other than its obligations as described under "- Obligation Payments; Fund Deposits; Prepayments And Other Payments" above), the Corporation will not be deemed in Default during the continuance of such inability. The term "force majeure" as used herein means, without limitation, the following: acts of God; strikes or other industrial disturbances; acts of public enemies; orders or restraints of any kind of the government of the United States of America, or of the State or of any of their departments, agencies or officials, or of any civil or military authority; insurrections; riots; landslides; earthquakes; fires; storms; droughts; floods; explosions; breakage or accident to machinery, transmission pipes or canals; and any other cause or event not reasonably within the control of the Corporation. The Corporation has agreed, however, to remedy with all reasonable dispatch the cause or causes preventing the Corporation from carrying out its agreement, provided that the settlement of strikes and other industrial disturbances will be entirely within the discretion of the Corporation and the Corporation will not be required to settle strikes, lockouts and other industrial disturbances by acceding to the demands of the opposing party or parties when such course is in the judgment of the Corporation unfavorable to the Corporation.

Remedies on Default. Whenever any Default described under "- Defaults Defined" above has happened and is continuing, the Bond Trustee, or the Issuer with the written consent of the Bond Trustee, may take one or any combination of the following remedial steps:

(a) If the Bond Trustee has declared the Series 2011 Bonds immediately due and payable pursuant to the acceleration provisions of the 2011 Bond Indenture, by written notice to the Corporation, declare an amount equal to all amounts then due and payable on the Series 2011 Bonds, whether by acceleration of maturity (as provided in the 2011 Bond Indenture) or otherwise, to be immediately due and payable as liquidated damages under the Loan Agreement and not as a penalty, whereupon the same will become immediately due and payable;

(b) Have reasonable access to and inspect, examine and make copies of the books and records and any and all accounts, data and income tax and other tax returns of the Corporation during regular business hours of the Corporation if reasonably necessary in the opinion of the Bond Trustee; or

(c) Take whatever action at law or in equity may appear necessary or desirable to collect the amounts then due and thereafter to become due, or to enforce performance and observance of any obligation, agreement or covenant of the Corporation under the Loan Agreement.

Any amounts collected pursuant to action taken as herein described will be paid into the Bond Fund and applied in accordance with the provisions of the 2011 Bond Indenture.

No Remedy Exclusive. Subject to the acceleration provisions of the 2011 Bond Indenture, no remedy in the Loan Agreement conferred upon or reserved to the Issuer or the Bond Trustee is intended to be exclusive of any other available remedy or remedies, but each and every such remedy will be cumulative and be in addition to every other remedy given under the Loan Agreement or now or hereafter existing at law or in equity. No delay or omission to exercise any right or power accruing upon any Default will impair any such right or power or be construed to be a waiver thereof, but any such right or power may be exercised from time to time and as often as may be deemed expedient. In order to entitle the Issuer or the Bond Trustee to exercise any remedy reserved to it as described herein, it will not be necessary to give any notice other than such notice as may be required by the Loan Agreement. Such rights and remedies as are given the Issuer under the Loan Agreement will also extend to the Bond Trustee, and the Bond Trustee and the Owners of the Series 2011 Bonds, subject to the provisions of the 2011 Bond Indenture, will be entitled to the benefit of all covenants and agreements contained in the Loan Agreement.

Agreement to Pay Attorneys' Fees, Costs and Expenses. If the Corporation defaults under any of the provisions of the Loan Agreement and the Issuer or the Bond Trustee employs attorneys or incurs other costs or expenses for the collection of payments required thereunder or the enforcement of performance or observance of any obligation or agreement on the part of the Corporation contained therein, the Corporation has agreed that it will on demand therefor pay to the Issuer or the Bond Trustee, as applicable, the reasonable fees, costs and expenses of such attorneys and such other costs or expenses so incurred by the Issuer or the Bond Trustee, as applicable.

No Additional Waiver Implied by One Waiver. If any agreement contained in the Loan Agreement is breached by either party and thereafter waived by the other party, such waiver will be limited to the particular breach so waived and may not be deemed to waive any other breach thereunder.

Term of Agreement

The Loan Agreement will remain in full force and effect from its date to and including September 1, 2032 or until such time as all of the Series 2011 Bonds and the fees and expenses of the Issuer and the Bond Trustee have been fully paid or provision made for such payments, whichever is later; provided that the Loan Agreement may be terminated prior to such date as provided in the Loan Agreement, but in no event before all of the obligations and duties of the Corporation thereunder have been fully performed, including, without limitation, the payments of all costs and fees mandated thereunder.

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APPENDIX D.

FORM OF APPROVING OPINION OF BOND COUNSEL

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May __, 2011

The Health, Educational and Housing Facilities Board
of the County of Sullivan, Tennessee
Sullivan, Tennessee

$76,165,000
The Health, Educational and Housing Facilities Board
of the County of Sullivan, Tennessee
Hospital Revenue Refunding Bonds
(Wellmont Health System Project)
Series 2011

Ladies and Gentlemen:

We have served as Bond Counsel in connection with the issuance by The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the "Board") of the Board's $76,165,000 Hospital Revenue Refunding Bonds (Wellmont Health System Project), Series 2011 (the "Bonds"). The Bonds have been issued pursuant to the terms of a Bond Trust Indenture dated as of May 1, 2011 (the "Indenture"), between the Board and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Trustee"). Unless otherwise defined, each capitalized term used in this opinion shall have the meaning given it in Article I of the Indenture.

The proceeds of the Bonds are to be loaned by the Board to Wellmont Health System (the "Borrower") pursuant to the terms of a Loan Agreement dated as of May 1, 2011 (the "Loan Agreement"), between the Board and the Borrower.

The Bonds will be dated their date of delivery. The Bonds are payable solely from the revenues, receipts and payments pledged pursuant to the Indenture. We refer you to the Bonds, the Indenture and the Loan Agreement for a description of the purposes for which the Bonds are issued and the security for them.

We have examined the Constitution of the State of Tennessee (the "State") and the laws of both the United States and the State, including, without limitation, the Internal Revenue Code of 1986, as amended (the "Code"), and the Act, and such certified proceedings and other documents of the Board as we deem necessary to render this opinion, including the resolution adopted by the Board on April 14, 2011 authorizing the issuance of the Bonds.

As to questions of fact material to our opinion, we have relied upon (a) representations of and compliance with covenants by the Borrower and the Board contained in the Indenture, the Loan Agreement and the Tax Compliance Agreement, (b) certificates of public officials furnished to us, (c) computations provided by Merrill Lynch, Pierce, Fenner & Smith Incorporated (the "Underwriter"), relating to the yield on the Bonds, and (d) certificates of representatives of the Borrower, the Board, the Trustee and other parties, including, without limitation, representations, covenants and certifications as to the use of the proceeds of the Bonds and the property financed or refinanced thereby, compliance with the arbitrage yield restriction and rebate requirements, the average reasonably expected economic life of the property being financed with the Bonds and other factual matters which are relevant to the opinions expressed in paragraph 5, in each case without undertaking any independent verification. We have assumed that all signatures on documents, certificates and instruments examined by us are genuine, all documents, certificates and instruments submitted to us as originals are authentic and all documents, certificates and instruments submitted to us as copies conform to the originals. In addition, we have assumed that all documents, certificates and instruments relating to this financing have been duly authorized, executed and delivered by all of their parties other than the Board, and we have further assumed the due organization, existence and powers of such other parties other than the Board.

Reference is made to the opinion, of even date hereof, of Hunter, Smith & Davis, LLP as counsel to the Borrower, with respect to the organization of the Borrower, the status of the Borrower as an organization described in Section 501(c)(3) of the Code, the power of the Borrower to enter into and perform its obligations under the Corporation Documents (as defined in the Loan Agreement), and other related documents to which the Borrower is a party, and the authorization, execution, delivery and enforceability of the Corporation Documents and the other documents by and against the Borrower.

Based on the foregoing, we are of the opinion that, under current law:

1. The Bonds have been duly authorized and issued in accordance with the Act and the Indenture and, subject to paragraph 4 below, constitute valid, binding and enforceable limited obligations of the Board, payable as to principal, premium, if any, and interest solely from the revenues, receipts and payments pledged to such purpose under the Indenture. The Bonds do not constitute a debt of the Board within the meaning of any constitutional or statutory limitation and is not in any respect a general obligation of the Board nor are the Bonds payable in any manner by taxation.

2. The Indenture and the Loan Agreement have been duly authorized, executed and delivered by the Board and, subject to paragraph 4 below, constitute valid and binding agreements of the Board, enforceable against the Board in accordance with their terms.

3. The Board's right, title and interest in the Loan Agreement (except for Authority's rights to payment of costs and expenses, indemnification and exemption from liability thereunder and Authority's right to receive notices) and in Series 2011 Obligation have been assigned to the

Trustee and, subject to paragraph 4 below, such assignment constitutes a valid and binding assignment by the Board, enforceable against the Board in accordance with its terms.

4. The enforceability of the obligations of the parties under the Bonds, the Indenture and the Loan Agreement and the Board's assignment of the Loan Agreement and the Series 2011 Obligation to the Trustee, is subject to the provisions of applicable bankruptcy, insolvency, reorganization, moratorium and similar laws, now or hereafter in effect, relating to or affecting the enforcement of creditors' rights. The enforceability of such obligations is also subject to usual equitable principles, which may limit the specific enforcement of certain remedies but which do not affect the validity of such documents. Certain indemnity provisions may be unenforceable pursuant to court decisions invalidating such indemnity agreements on grounds of public policy.

5. Interest on the Bonds is excludable from gross income for federal income tax purposes and is not a specific item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations. Further, for purposes of alternative minimum tax imposed on corporations (as defined for federal income tax purposes under Section 56 of the Code), interest on the Bonds must be included in the calculation of adjusted current earnings. We express no opinion regarding other federal tax consequences arising with respect to the Bonds.

In providing the opinions set forth in this paragraph, we are assuming continuing compliance with the Covenants (as hereinafter defined) by the Board and the Borrower. The Code and the regulations promulgated thereunder contain a number of requirements that must be satisfied after the issuance of the Bonds in order for interest on the Bonds to be and remain excludable from gross income for purposes of federal income taxation. These requirements include, by way of example and not limitation, the requirement that the Borrower maintain its status as an organization described in Section 501 (c)(3) of the Code, restrictions on the use, expenditure and investment of the proceeds of the Bonds and the use of the property financed or refinanced by the Bonds, limitations on the source of the payment of and the security for the Bonds, and the obligation to rebate certain excess earnings on the gross proceeds of the Bonds to the United States Treasury. The Indenture, the Loan Agreement and the Tax Compliance Agreement contain covenants (the "Covenants") under which the Board and the Borrower have agreed to comply with such requirements. Failure by the Board or the Borrower to comply with their respective Covenants could cause interest on the Bonds to become includable in gross income for federal income tax purposes retroactively to their date of issue. In the event of noncompliance with the Covenants, the available enforcement remedies may be limited by applicable provisions of law and, therefore, may not be adequate to prevent interest on the Bonds from becoming includable in gross income for federal income tax purposes. Compliance by the Board with its respective Covenants does not require the Board to make any financial contribution for which it does not receive funds from the Borrower.

This opinion speaks as of its date, is based on current legal authority and precedent, covers certain matters not directly addressed by such authority and precedent, and represents our judgment as to the proper treatment of interest on the Bonds for federal income tax purposes.

This opinion does not contain or provide any opinion or assurance regarding the future activities of the Board or the Borrower or about the effect of future changes in the Code, the applicable regulations, the interpretation thereof or the enforcement thereof by the Internal Revenue Service. The Board and the Borrower have covenanted, however, to comply with the requirements of the Code.

Certain requirements and procedures contained, incorporated or referred to in the Indenture, the Loan Agreement and the Tax Compliance Agreement, including the Covenants, may be changed and certain actions may be taken or omitted under the circumstances and subject to the terms and conditions set forth in such documents.

6. The Bonds and the interest thereon are exempt from all state, county and municipal taxation in the State, except for inheritance, transfer and estate taxes and except to the extent that the Bonds and the interest thereon are included within the measure of certain privilege and excise taxes imposed under State law. We express no opinion regarding (i) other State tax consequences arising with respect to the Bonds or (ii) any consequences arising with respect to the Bonds under the tax laws of any state or local jurisdiction other than the State. Prospective purchasers of the Bonds should consult its own tax advisors regarding state and local tax issues not covered by this opinion, including the tax status of interest on the Bonds in a particular state or local jurisdiction other than the State.

Our services as Bond Counsel to the Board have been limited to rendering the foregoing opinions based on our review of such legal proceedings and other documents as we deem necessary to approve the validity of the Bonds and tax-exempt status of the interest on them and the enforceability of the Indenture and the Loan Agreement. The foregoing opinions are in no respect an opinion as to the business or financial resources of the Board or the Borrower or the ability of the Board or the Borrower to provide for the payment of the Bonds or the accuracy or completeness of any information, including the Board's Preliminary Official Statement dated April 28, 2011, and Official Statement dated May 2, 2011, that anyone may have relied upon in making the decision to purchase the Bonds.

This opinion is given as of the date hereof, and we assume no obligation to revise or supplement this opinion to reflect any facts or circumstances that may hereafter come to our attention, or any changes in law that may hereafter occur.

Very truly yours,

APPENDIX E.

SUMMARY OF THE CONTINUING DISCLOSURE AGREEMENT

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SUMMARY OF THE CONTINUING DISCLOSURE AGREEMENT

The Continuing Disclosure Agreement will be entered into by the Corporation, Wellmont, Inc., Wellmont Foundation and Wellmont Hawkins County Memorial Hospital, Inc. The following is a summary of the proposed form of the Continuing Disclosure Agreement. It is expected that the executed Continuing Disclosure Agreement will conform to this summary in all material respects; however, in the event of conflict between the executed version of the Continuing Disclosure Agreement and this summary, the executed version will control.

This summary is being provided in the form of excerpts from the proposed Continuing Disclosure Agreement. Section references in these excerpts correspond to the sections of the proposed form of the Continuing Disclosure Agreement.

Excerpts from the proposed form of Continuing Disclosure Agreement:

Section 1. Definitions

Capitalized terms not otherwise defined in this Agreement shall have the meaning assigned in the Indenture. In addition, the terms set forth below shall have the meaning assigned unless the context clearly otherwise requires:

"**Bonds**" means the $76,165,000 Hospital Revenue Refunding Bonds (Wellmont Health System Project), Series 2011, issued by the Issuer.

"**Corporation**" means Wellmont Health System, a Tennessee nonprofit corporation and a 501(c)(3) organization under the Internal Revenue Code.

"**EMMA**" means the MSRB's Electronic Municipal Market Access System (EMMA) established pursuant to the Rule.

"**Indenture**" means the Bond Trust Indenture dated as of May 1, 2011 between the Issuer and the Trustee.

"**Issuer**" means The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, a Tennessee public corporation.

"**MSRB**" means the Municipal Securities Rulemaking Board.

"**Obligors**" means the Corporation and the other Obligors described in the opening paragraph of this Agreement.

"**Official Statement**" means the Official Statement dated May 2, 2011 with respect to the Bonds.

"**Rule**" means Rule 15c2-12 adopted by the Securities and Exchange Commission, as the same may be amended from time to time.

"**Trustee**" means The Bank of New York Mellon Trust Company, N.A., as trustee under the Indenture.

Section 2. Purpose and Beneficiaries of this Agreement

This Agreement is entered into by the Obligors for the benefit of the holders of the Bonds in order to assist the underwriter or underwriters for the Bonds in complying with the requirements of the Rule.

Section 3. Annual Financial Information

(a) Within 150 days after the end of each fiscal year, the Obligors shall file with the MSRB the following information:

(1) ***Operating data.*** Information about operating statistics for such fiscal year, and comparative information for the prior fiscal year, but not partial year information, substantially in the form included in APPENDIX A to the Official Statement under the following heading:

"FACILITIES—Historical Utilization"

(2) ***Financial information.*** Information about financial performance for such fiscal year, and comparative information for the prior fiscal year, but not partial year information, substantially in the form included in APPENDIX A to the Official Statement under the following headings:

"HISTORICAL FINANCIAL INFORMATION—Summary Financial Information"

"HISTORICAL FINANCIAL INFORMATION—Sources of Patient Service Revenue"

"HISTORICAL FINANCIAL INFORMATION—Estimated Days Cash on Hand"

"HISTORICAL FINANCIAL INFORMATION—Historical Annual Debt Service Coverage"

(b) The Obligors may omit or modify any part of the annual information required by this section if the operations to which it relates have been discontinued or materially changed. The Obligors will include an explanation to that effect as part of the annual information for the year in which such event first occurs.

(c) If any amendment is made to this Agreement, the annual information for the year in which such amendment is made shall contain a description of the reasons for such amendment and its impact on the type of information being provided.

Section 4. Audited Financial Statements

(a) Within 30 days after receipt by the Obligors, but in no event more than 150 days after the end of each fiscal year, the Obligors shall file with the MSRB audited financial statements of the Corporation and its affiliates. The audited financial statements shall be prepared on a basis consistent with the accounting principles and auditing standards used to prepare the financial statements attached as APPENDIX B to the Official Statement, as such standards may be modified from time to time under generally accepted accounting principles and auditing standards applicable to the Obligors.

(b) The Obligors operate acute care hospitals and related healthcare facilities that are part of a healthcare delivery system that is managed and supervised by the Corporation. The Corporation serves as the parent organization for the Obligors. The annual audited financial statements of the Corporation are consolidated statements that provide financial information with respect to the Corporation and its affiliates described in the audit report, including the other Obligors. The Obligors do not have audited financial statements prepared for the Obligors alone. The Obligors intend to comply with their continuing disclosure obligations under this Agreement by providing consolidated annual audited financial information for the Corporation and its affiliates that will include information about the Obligors substantially in the form included in APPENDIX B to the Official Statement.

Section 5. Quarterly Financial Information

(a) Within 45 days after the end of each of the first three quarters of the fiscal year, the Obligors shall file with the MSRB the following information:

(1) ***Operating data.*** Information about operating statistics for the period ending on the last day of such quarter, together with comparative information for the corresponding period of the prior fiscal

year, substantially in the form included in APPENDIX A to the Official Statement under the following heading:

"FACILITIES—Historical Utilization"

(2) ***Financial information.*** Information about financial performance for the period ending on the last day of such quarter, together with comparative information for the corresponding period of the prior fiscal year, substantially in the form included in APPENDIX A to the Official Statement under the following headings:

"HISTORICAL FINANCIAL INFORMATION—Summary Financial Information"

"HISTORICAL FINANCIAL INFORMATION—Sources of Patient Service Revenue"

"HISTORICAL FINANCIAL INFORMATION—Estimated Days Cash on Hand"

"HISTORICAL FINANCIAL INFORMATION—Historical Annual Debt Service Coverage"

(b) The Obligors may omit or modify any part of the quarterly information required by this section if the operations to which it relates have been discontinued or materially changed. The Obligors will include an explanation to that effect as part of the quarterly information for the quarter in which such event first occurs (or, if such event occurs in the last quarter of the fiscal year, as part of the annual financial information provided by Section 4).

Section 6. Event Disclosure

(a) In a timely manner not in excess of 10 business days after the occurrence of the event, the Obligors shall file with the MSRB notice of the occurrence of any of the following events affecting the Bonds:

(1) principal and interest payment delinquencies;

(2) non-payment related defaults, if material;

(3) unscheduled draws on debt service reserves reflecting financial difficulties;

(4) unscheduled draws on credit enhancements reflecting financial difficulties;

(5) substitution of credit or liquidity providers, or their failure to perform;

(6) adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notice 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;

(7) modifications to rights of the holders of the Bonds, if material;

(8) Bond calls, if material, and tender offers;

(9) defeasances;

(10) release, substitution or sale of property securing repayment of the Bonds, if material;

(11) rating changes;

(12) bankruptcy, insolvency, receivership or similar events affecting an Obligor;

(13) the consummation of a merger, consolidation, or acquisition involving an Obligor or the sale of all or substantially all of the assets of an Obligor, 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

(14) appointment of a successor or additional trustee or the change of name of a trustee, if material.

(b) In a timely manner the Obligors shall file with the MSRB notice of failure to make a filing, on or before the date specified in this Agreement, of annual information required by Section 3 or Section 4 of this Agreement.

Section 7. Consequences of Failure to File

If the Obligors fail to comply with any provision of this Agreement, the holder of any Bond may seek mandamus or specific performance by court order, to cause the Obligors to comply with their obligations under this Agreement. A default under this Agreement shall not be deemed an event of default under the Indenture or any other financing document related to the issuance of the Bonds, including without limitation the Loan Agreement and the Master Indenture referred to in the Indenture. The sole remedy under this Agreement shall be an action to compel performance.

Section 8. Amendment

This Agreement may be amended by the Obligors if the amendment is required by, or consistent with, changes to, or interpretations of, the Rule made by governmental authority after the Bonds are issued.

Section 9. Termination

(a) This Agreement shall terminate when (i) all Bonds have been paid or defeased in accordance with the terms of the Indenture or (ii) the continuing disclosure obligation of the Rule is no longer applicable to the Bonds.

(b) Any Obligor may terminate its obligations under this Agreement if and when such Obligor no longer remains an obligated person with respect to the Bonds.

Section 10. Filing

(a) The Obligors shall make the information filings required or permitted by this Agreement with the MSRB through the MSRB's Electronic Municipal Market Access System (EMMA).

(b) All documents provided to the MSRB pursuant to this Agreement shall be filed in electronic format as prescribed by the MSRB and shall be accompanied by identifying information as prescribed by the MSRB.

(c) Information about the filing system and requirements of EMMA is available at www.emma.msrb.org.

Section 11. Additional Information

The Obligors may, in their sole discretion, file with the MSRB additional notices with information not required by this Agreement or the Rule. Such additional filings may be discontinued by the Obligors at any time in their sole discretion.

Section 12. No Indirect Beneficiaries

This Agreement is for the benefit of the underwriter or underwriters for the Bonds and the holders of the Bonds and shall not create rights or benefits for any other person or entity.

Section 13. Agent for Filings

The Obligors may appoint an agent for purposes of making the filings required or permitted by this Agreement, but no such appointment, or failure of such agent to perform, shall relieve the Obligors of their responsibilities under this Agreement.

Section 14. Governing Law

This Agreement shall be governed by the laws of the State of Tennessee.

Dated: _____.

[Execution by Obligors]

_____

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APPENDIX F.

THE DTC BOOK ENTRY SYSTEM

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The DTC Book Entry System

1. The Depository Trust Company ("DTC"), New York, New York, will act as securities depository for the Bonds (the "Securities"). The Securities 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 Security certificate will be issued for each maturity of the Securities, in the aggregate principal amount of such maturity, and will be deposited with DTC.

2. 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 instrument from over 100 countries that DTC's participants ("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 Standard & Poor's highest rating: AAA. 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 and www.dtc.org.

3. Purchases of Securities under the DTC system must be made by or through Direct Participants, which will receive a credit for the Securities on DTC's records. The ownership interest of each actual purchaser of each Security ("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 are, however, 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 Securities are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in Securities, except in the event that use of the book-entry system for the Securities is discontinued.

4. To facilitate subsequent transfers, all Securities 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 Securities 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 Securities; DTC's records reflect only the identity of the Direct Participants to whose accounts such Securities are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

5. 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. Beneficial Owners of Securities may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Securities, such as redemptions, tenders, defaults, and proposed amendments to the Security documents. For example, Beneficial Owners of Securities may wish to ascertain that the nominee holding the Securities for their benefit has agreed to obtain and transmit notices to Beneficial Owners.

In the alternative, Beneficial Owners may wish to provide their names and addresses to the registrar and request that copies of notices be provided directly to them.

6. Redemption notices shall be sent to DTC. If less than all of the Securities within one issue 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.

7. Neither DTC nor Cede & Co. (nor such other DTC nominee) will consent or vote with respect to the Securities unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Issuer 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 Securities are credited on the record date (identified in a listing attached to the Omnibus Proxy).

8. Redemption proceeds, distributions and dividend payments on the Securities 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 Issuer or Trustee on the payable 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 Issuer, or the Trustee, 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 Issuer and 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.

9. A Beneficial Owner shall give notice to elect to have its Securities purchased or tendered, through its Participant, to the Trustee, and shall effect delivery of such Securities by causing the Direct Participant to transfer the Participant's interest in the Securities, on DTC's records, to the Trustee. The requirement for physical delivery of Securities in connection with an optional tender or a mandatory purchase will be deemed satisfied when the ownership rights in the Securities are transferred by Direct Participants on DTC's records and followed by a book-entry credit of tendered Securities to the Trustee's DTC account.

10. DTC may discontinue providing its services as depository with respect to the Securities at any time by giving reasonable notice to the Issuer or Trustee. Under such circumstances, in the event that a successor securities depository is not obtained, Security certificates are required to be printed and delivered.

11. The Issuer may decide to discontinue use of the system of book-entry-only transfers through DTC (or a successor securities depository). In that event, Security certificates will be printed and delivered to DTC.

12. The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the Issuer and the Corporation believe to be reliable, but neither the Issuer nor the Corporation takes responsibility for the accuracy thereof.

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Exhibit 11.5

Attachment B

Wellmont Audits - External Audited Financial Statements for 2011 to 2014

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2010 and 2009

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

Table of Contents

KPMG LLP
Suite 1000
401 Commerce Street
Nashville, TN 37219-2422

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

We have audited the accompanying consolidated balance sheets of Wellmont Health System and affiliates (Wellmont) 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 Wellmont'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 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 Wellmont's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that 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 consolidated financial position of Wellmont Health System and affiliates as of June 30, 2010 and 2009, and the consolidated results of their operations and changes in net assets, and cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

October 28, 2010

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2010 and 2009

(Dollars in thousands)

Assets		2010	2009
Current assets:			
Cash and cash equivalents	$	35,711	60,889
Assets limited as to use, required for current liabilities		1,815	2,201
Patient accounts receivable, less allowance for uncollectible accounts of approximately $25,113 and $27,890 in 2010 and 2009, respectively		94,057	98,071
Other receivables		10,919	11,173
Inventories		18,294	17,169
Prepaid expenses and other current assets		7,003	6,040
Total current assets		167,799	195,543
Assets limited as to use, net of current portion		301,807	245,600
Land, buildings, and equipment, net		450,205	442,610
Other assets:			
Long-term investments		32,391	31,974
Investments in affiliates		32,019	31,976
Deferred debt expense, net		4,644	4,824
Goodwill, net		9,501	9,509
Other		730	798
		79,285	79,081
Total assets	$	999,096	962,834
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	11,958	13,197
Lines of credit/short-term note payable		14,000	15,811
Accounts payable and accrued expenses		74,679	77,139
Estimated third-party payor settlements		11,672	12,441
Current portion of other long-term liabilities		7,251	6,352
Total current liabilities		119,560	124,940
Long-term debt, less current portion		467,833	474,608
Other long-term liabilities, less current portion		47,364	38,422
Total liabilities		634,757	637,970
Net assets:			
Unrestricted		358,620	320,030
Temporarily restricted		4,551	3,589
Permanently restricted		1,168	1,245
Total net assets		364,339	324,864
Commitments and contingencies			
Total liabilities and net assets	$	999,096	962,834

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2010 and 2009

(Dollars in thousands)

	2010	2009
Revenue:		
Net patient service revenue	$ 692,920	680,056
Other revenues	31,472	27,842
Total revenue	724,392	707,898
Expenses:		
Salaries and benefits	310,667	323,801
Medical supplies and drugs	150,143	141,044
Purchased services	74,922	81,031
Interest	20,110	16,013
Provision for bad debts	35,293	33,402
Depreciation and amortization	43,711	42,957
Other	66,734	62,604
Total expenses	701,580	700,852
Income from operations	22,812	7,046
Nonoperating gains (losses):		
Investment income	1,012	4,181
Derivative valuation adjustments	(2,693)	(5,747)
Other, net	(1,870)	(625)
Nonoperating losses, net	(3,551)	(2,191)
Revenue and gains in excess of expenses and losses before discontinued operations	19,261	4,855
Discontinued operations	(1,109)	(4,455)
Revenue and gains in excess of expenses and losses	18,152	400
Other changes in unrestricted net assets:		
Change in net unrealized gains (losses) on investments	22,312	(60,663)
Net assets released from restrictions for additions to land, buildings, and equipment	1,555	2,758
Change in the funded status of benefit plans and other	(3,429)	(13,568)
Increase (decrease) in unrestricted net assets	38,590	(71,073)
Changes in temporarily restricted net assets:		
Contributions	2,934	1,944
Net assets released from temporary restrictions	(1,972)	(3,154)
Increase (decrease) in temporarily restricted net assets	962	(1,210)
Changes in permanently restricted net assets – investment (loss) income	(77)	645
Change in net assets	39,475	(71,638)
Net assets, beginning of year	324,864	396,502
Net assets, end of year	$ 364,339	324,864

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2010 and 2009

(Dollars in thousands)

	2010	2009
Cash flows from operating activities:		
Change in net assets	$ 39,475	(71,638)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	43,755	43,393
Loss on disposal of land, buildings, and equipment	1,282	659
Equity in gain of affiliated organizations	(6,773)	(5,549)
Amortization of deferred financing costs	180	238
Net realized and unrealized (gains) losses on investments, other than trading	(17,994)	66,199
Provision for bad debts	35,950	33,821
Change in fair value of derivative instruments	2,693	5,747
Changes in assets and liabilities:		
Patient accounts receivable	(31,936)	(22,378)
Other current assets	(2,088)	(385)
Other assets	322	3,735
Accounts payable and accrued expenses	2,722	(5,796)
Estimated third-party payor settlements	(769)	10,355
Other current liabilities	899	1,437
Other liabilities	7,933	11,101
Net cash provided by operating activities	75,651	70,939
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	88,887	67,580
Purchase of investments	(127,131)	(25,207)
Purchase of land, buildings, and equipment	(55,684)	(86,623)
Proceeds from the sale of buildings and equipment	4,357	31,251
Cash paid for acquisitions	(2,421)	—
Investment in affiliated organizations	—	(4,453)
Distributions from affiliated organizations	6,730	7,181
Distributions to affiliated organizations	(1,684)	(924)
Net cash used in investing activities	(86,946)	(11,195)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	14,000	484
Payments on long-term debt	(12,083)	(11,005)
Payments on line of credit	(15,800)	(2,121)
Net cash used in financing activities	(13,883)	(12,642)
Net (decrease) increase in cash and cash equivalents	(25,178)	47,102
Cash and cash equivalents, beginning of year	60,889	13,787
Cash and cash equivalents, end of year	$ 35,711	60,889

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of $1,290 and $18,050 in 2010 and 2009, respectively.

Additions to property and equipment financed through current liabilities of $5,182 and $5,977 in 2010 and 2009, respectively.

See accompanying notes to consolidated financial statements.

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont) was formed to assume operations of Bristol Regional Medical Center (BRMC) and Holston Valley Health Care, Inc. (HVHC), including Holston Valley Medical Center, Inc. (HVMC), and to act as sole corporate member of its consolidated foundations. Effective July 1, 1996, under terms of an agreement and plan of consolidation and merger, BRMC and HVHC, including HVMC, were merged and consolidated into Wellmont. Effective January 1, 1997, Lonesome Pine Hospital (LPH), a Virginia corporation, was merged into Wellmont under terms of a plan of merger and merger agreement. Effective July 1, 2000, Hawkins County Memorial Hospital (HCMH) transferred its operations and operating assets to Wellmont Hawkins County Memorial Hospital (WHCMH), a tax-exempt organization that is wholly owned and controlled by Wellmont. Hancock County Hospital (HCH), a critical access hospital, was opened in March 2005 to help provide for the immediate healthcare needs of the residents of Sneedville and the surrounding counties. As of July 16, 2007, Wellmont acquired Jenkins Community Hospital (Jenkins) in Kentucky. As of August 1, 2007, Wellmont acquired two hospitals in Virginia, Lee Regional Medical Center in Pennington Gap and Mountain View Regional Medical Center in Norton. On May 30, 2008, Wellmont acquired the Holston Valley Cath Lab, an outpatient lab. On May 1, 2010, Wellmont acquired Cardiovascular Associates.

As of April 30, 2009, Wellmont closed Jenkins, sold the majority of the facility's property and equipment to Appalachian Regional Healthcare, Inc for $1,000 and recorded a loss on sale of approximately $256. The consolidated financial statements for the years ended June 30, 2010 and 2009 present Jenkins as a discontinued operation. The operating losses of $474 and $3,659 for the years ended June 30, 2010 and 2009, respectively, and the impairment are included in the classification of discontinued operations.

As of June 30, 2010, it was announced that Wellmont will sell the majority of Medical Mall Pharmacy's assets to a national pharmacy company for $1,300 plus inventory value. The consolidated financial statements for the years ended June 30, 2010 and 2009 present Medical Mall Pharmacy as a discontinued operation. The operating losses of $635 and $540 for the years ended June 30, 2010 and 2009, respectively, are included in the classification of discontinued operations. The sale was completed on September 23, 2010.

All acute care operations remain separately licensed and are treated as operating divisions within Wellmont. Wellmont's operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

The consolidated financial statements include the acute care operations of the above entities along with:

- Wellmont Foundation (the Foundation), which was created from the merger of Bristol Regional Medical Center Foundation and Holston Valley Health Care Foundation, Inc. The Foundation conducts fund-raising activities for the benefit of Wellmont.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate a pharmacy and physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

- The Alzheimer's Center of East Tennessee was merged into Wellmont and changed its name to Wellmont Madison House effective September 1, 1997. Wellmont is the sole corporate member and the consolidated financial statements include the operations of this entity.

All significant intercompany accounts and transactions have been eliminated in the accompanying consolidated financial statements.

(2) Significant Accounting Policies

A summary of significant accounting policies follows:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) 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. Significant estimates include: allowances for contractual adjustments and bad debts; third-party payor settlements; valuation of investments, land, buildings, equipment, and goodwill; and self-insurance and other liabilities. Actual results could differ from these estimates.

(b) Cash and Cash Equivalents

Wellmont considers all highly liquid investments with a maturity of three months or less when purchased, excluding amounts whose use is limited by board of director's designation or other arrangements under trust agreements, to be cash equivalents.

(c) Investments

Marketable equity securities and debt securities are recorded at fair value and classified as other than trading. Fair value is determined primarily using quoted prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date. However, Wellmont also uses observable and unobservable inputs for investments without quoted market prices to determine the fair value of certain investments at the measurement date. Investments in limited partnerships are recorded at fair value as determined by the partnership using net asset value. Wellmont elected to early adopt the measurement provisions of Accounting Standards Update No. 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent),* to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. Investments in affiliates in which Wellmont has significant influence but does not control are reported on the equity method of accounting, which represents Wellmont's equity in the underlying net book value. Long-term investments include those investments that have not been designated by the board of directors for specific purposes and are also not intended to be used for the liquidation of current liabilities. Investment income is recognized when earned.

Realized gains and losses are determined on the specific-identification method and included in investment income with interest and dividends. Investment income is reported net of related investment fees. Unrealized gains and losses are included in other changes in unrestricted net assets except for losses determined to be other than temporary, which are considered realized losses and included in investment income.

On July 1, 2008, Wellmont adopted new guidance issued by the Financial Accounting Standards Board (FASB), which defines fair value, establishes a framework for the measurement of fair value, and enhances disclosures about fair value measurements now codified into Accounting Standards Codification (ASC) 850. ASC 850 statement does not require any new fair value measures and did not have a material impact on Wellmont's consolidated financial statements for the year ended June 30, 2009, however, expanded fair value disclosures have been provided in note 19.

(d) Assets Limited as to Use

Assets limited as to use primarily include assets held by trustees under bond indenture and self-insurance agreements, as well as designated assets set aside by the board of directors for future capital improvements, over which the board of directors retains control and may, at its discretion, subsequently use for other purposes. Amounts required to meet current liabilities of Wellmont have been reclassified to current assets in the accompanying consolidated balance sheets.

(e) Inventories

Inventories are stated at the lower of cost or market value and are valued principally by the first-in, first-out, and average-cost methods.

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, if purchased, or fair value at date of donation. Depreciation is computed using the straight-line method based on the estimated useful life of the asset, ranging from 3 to 40 years. Buildings and equipment held under capital leases are recorded at net present value of future lease payments and are amortized on a straight-line basis over the shorter of the lease term or estimated useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Upon sale or retirement of land, buildings, or equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss, if any, is included in other revenues on the consolidated statements of operations and changes in net assets. 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.

Wellmont evaluates long-lived assets for impairment on annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows

(Dollars in thousands)

expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset.

(g) Goodwill

Goodwill represents the difference between the cost of net assets acquired and estimated fair value at purchase date, and is being amortized using the straight-line method over periods of 5 to 15 years. For goodwill acquired by its taxable entities, the FASB has implemented a nonamortization approach to goodwill. However, the effective date for not-for-profit entities is not effective until fiscal year 2011 for Wellmont and, as such, Wellmont continues to amortize the goodwill associated with its tax-exempt entities. Wellmont assesses the recoverability and the amortization period of goodwill for not-for-profit entities by determining whether the amount can be recovered through undiscounted cash flows of the business acquired, excluding interest and amortization, over the remaining amortization period. If impairment is indicated by this analysis, measurement of the impairment recognized is based on the difference between the fair value and the carrying amount of the asset. Management considers external factors relating to each acquired business, including local market developments, regional and national trends, regulatory developments, and other pertinent factors in making its assessment. Goodwill for Wellmont's for-profit/taxable entities is reviewed for impairment at least annually in accordance with the provisions of FASB ASC 350, *Intangibles – Goodwill and Other* (Statement No. 142, *Goodwill and Other Intangible Assets*). The goodwill impairment test is a two-step test. Under the first step, the fair value of the reporting unit is compared with its carrying value (including goodwill). If the fair value of the reporting unit is less than its carrying value, an indication of goodwill impairment exists for the reporting unit and the enterprise must perform step two of the impairment test. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. A summary of goodwill and related amortization for the years ended June 30 follows:

	2009	Additions	Decreases	2010
Goodwill	$ 12,604	—	—	12,604
Amortization	(3,095)	(8)	—	(3,103)
	$ 9,509	(8)	—	9,501

(Continued)

(Dollars in thousands)

	2008	Additions	Decreases	2009
Goodwill	$ 12,771	—	(167)	12,604
Amortization	(3,130)	(30)	65	(3,095)
	$ 9,641	(30)	(102)	9,509

(h) Deferred Debt Expense

Deferred debt expense is amortized over the life of the related bond issues using the effective-interest method.

(i) Derivative Financial Instruments

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) Asset Retirement Obligations

Asset retirement obligations (AROs) are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value, and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, Wellmont records period-to-period changes in the ARO liability resulting from the passage of time and revisions to either the timing or the amount of the original estimate of undiscounted cash flows. Wellmont derecognizes ARO liabilities when the related obligations are settled.

(k) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by Wellmont has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by Wellmont in perpetuity. Generally, donors of permanently restricted assets permit use of all or part of the income earned on related investments for general or specific purposes.

Temporarily restricted net assets relate primarily to amounts held by the Foundation and include amounts restricted for future capital expenditures and for operations of such areas as children's healthcare services, hospice, and cancer research.

(Continued)

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2010 and 2009 primarily included amounts related to the purchase of buildings and equipment for pediatrics, cancer, and other healthcare operations.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

Patient accounts receivable are reported net of both an allowance for uncollectible accounts and an allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, TennCare, Medicaid, and other third-party payment programs. Wellmont's policy does not require collateral or other security for patient accounts receivable. Wellmont routinely obtains assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans, or policies.

(m) Revenue and Gains in Excess of Expenses and Losses

The consolidated statements of operations and changes in net assets include revenue and gains in excess of expenses and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include changes in net unrealized gains (losses) on investments other-than-trading securities, changes in the funded status of Wellmont's defined benefit plans, contributions of long-lived assets, including assets acquired using contributions that, by donor restriction, were to be used for the purpose of acquiring such assets, and cumulative effects of changes in accounting principles.

For purposes of financial statement display, those activities directly associated with Wellmont's mission of providing healthcare services are considered to be operating activities. Nonoperating activities primarily include investment and related activities. Other operating revenues primarily include cafeteria, rental, and income from affiliates.

(n) Contributed Resources

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted contributions, and are excluded from revenue and gains in excess of expenses and losses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit

donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. Gifts are reported as either a temporarily or permanently restricted contribution if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions. Unrestricted contributions are included in other revenues.

(o) Federal Income Taxes

The Wellmont entities are primarily classified as organizations exempt from federal income taxes under Section 501(a) as entities described in Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been included for these entities in the consolidated financial statements. The operations of Wellmont, Inc. and its subsidiaries are subject to state and federal income taxes, which are accounted for in accordance with ASC 740, *Income Taxes*; however, such amounts are not material.

On July 1, 2007, Wellmont adopted new guidance issued by on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

(p) New Accounting Pronouncements

Effective July 1, 2008, Wellmont adopted new guidance issued by FASB, which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA) now codified into ASC 958, *Not-for-Profit Entities*. Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of four individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a

manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

On June 30, 2009, Wellmont adopted guidance issued by the FASB for subsequent events, now codified into ASC 855, *Subsequent Events*. ASC 855 defines the period after the balance sheet date during which management shall evaluate events or transactions that may occur for potential recognition or disclosure, the circumstances under which an organization shall recognize events occurring after the balance sheet date and the disclosures that an organization shall make about those events or transactions. ASC 855 defines two types of subsequent events. The first type consists of events or transactions that provide additional evidence about conditions that existed at the date of the balance sheet, including the estimates inherent to the process of preparing financial statements (i.e., recognized subsequent events). The second type consists of events that provide evidence about conditions that did not exist at the date of the balance sheet but arose after the date (i.e., nonrecognized event).

Management evaluated all events and transactions that occurred through October 28, 2010. Other than described in note 11, Wellmont did not have any material subsequent events during this period.

On July 1, 2009, the FASB issued Statement No. 168, *The FASB Accounting Standards Codification™ and the Hierarchy of Generally Accepted Accounting Principles* (Statement 168). Statement 168 is the single source of authoritative nongovernmental GAAP, superseding existing FASB, American Institute of Certified Public Accountants, Emerging Issues Task Force, and related accounting literature. Statement 168 reorganizes the thousands of pages of GAAP pronouncements into roughly 90 accounting topics and displays them using a consistent structure. Also included is relevant Securities and Exchange Commission guidance organized using the same topical structure in separate sections. Statement 168 is effective for interim and annual periods ending after September 15, 2009. The adoption of Statement 168 had no significant effect on the Wellmont's consolidated financial statements.

(q) Reclassifications

Certain 2009 amounts have been reclassified to conform to the 2010 consolidated financial statement presentation.

(Dollars in thousands)

(3) 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 consolidated statements of operations and changes in net assets is as follows for the years ended June 30:

		2010	2009
Gross patient service charges	$	2,158,847	2,178,018
Less:			
Contractual adjustments and other discounts		(1,411,435)	(1,440,519)
Charity care		(54,492)	(57,443)
		(1,465,927)	(1,497,962)
Net patient service revenue	$	692,920	680,056

(4) Third-Party Reimbursement Arrangements

Wellmont renders services to patients under contractual arrangements with the Medicare and Medicaid programs. The Medicaid program in Tennessee was replaced with a managed care program known as TennCare, which was designed to cover previous Medicaid eligible enrollees. Amounts earned under these contractual arrangements are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Management believes that adequate provision has been made for any adjustments that may result from such reviews. Participation in these programs subjects Wellmont to significant rules and regulations; failure to adhere to such could result in fines, penalties, or expulsion from the programs.

Wellmont contracts with various managed care organizations under the TennCare program. TennCare reimbursement for both inpatient and outpatient services is based upon prospectively determined rates, including diagnostic-related group assignments, fee schedules, and per diem amounts. Reimbursement under the Virginia Medicaid program is also based upon prospectively determined amounts.

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid-eligible and other low income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

(Dollars in thousands)

Net patient service revenue in 2010 and 2009 related to Medicare, TennCare, and Virginia Medicaid and net patient accounts receivable at June 30, 2010 and 2009 from Medicare, TennCare, and Virginia Medicaid were as follows:

		2010	2009
Net patient service revenue:			
Medicare	$	277,372	272,259
TennCare		22,918	22,509
Virginia Medicaid		23,536	19,036
Net patient accounts receivable:			
Medicare	$	41,125	39,852
TennCare		2,206	4,072
Virginia Medicaid		3,739	3,172

Wellmont has filed cost reports with Medicare and Virginia Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Virginia Medicaid cost reports have been audited by the intermediary through June 30, 2006.

Wellmont has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, per diem rates, and discounts from established charges.

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased (decreased) approximately $863 and $(2,600) in 2010 and 2009, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of final settlements, and years that are not longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2010 could differ materially from actual settlements based on the results of third-party audits.

(5) Charity Care and Community Services

Wellmont accepts all patients within its primary service area regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies that consider, among other factors, generally recognized poverty income levels.

Wellmont maintains records to identify and monitor the level of charity care it provides. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were $54,492, $15,567, and

(Dollars in thousands)

2.52%, respectively, for the year ended June 30, 2010 and $57,443, $16,203, and 2.63%, respectively, for the year ended June 30, 2009.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled $55,461 and $57,212 for the years ended June 30, 2010 and 2009, respectively.

Wellmont also provides services to the community at large for which it receives little or no payment. Health evaluations, screening programs, and specific services for the elderly and homebound are other services supplied. Wellmont also provides public health education, trains new health professionals, and conducts health research.

(6) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in net income of affiliates was approximately $6,773 and $5,549 for the years ended June 30, 2010 and 2009, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont made additional contributions of $0 and $4,453 during 2010 and 2009, respectively, to affiliates, which increased Wellmont's overall investment in affiliates. Wellmont received distributions of $6,730 and $7,181 during 2010 and 2009, respectively, which reduced Wellmont's overall investment in the affiliates.

The following table summarizes the unaudited aggregate financial information of Wellmont's investments in affiliates:

		2010	2009
Total assets	$	129,720	137,737
Total liabilities		13,943	39,913
Total net assets	$	115,777	97,824
Net revenues	$	166,815	178,253
Expenses		142,534	159,004
Revenues in excess of expenses	$	24,281	19,249

(Continued)

(Dollars in thousands)

Wellmont's equity investment in these affiliates and its ownership percentage as of June 30, 2010 and 2009 are as follows:

	Amount		Percentage	
	2010	2009	2010	2009
Takoma Regional Hospital	$ 12,645	12,302	60%	60%
Holston Valley Imaging Center (HVIC)	8,048	9,047	75	75
Advanced Home Care (AHC)	6,092	6,092	6	6
Spectrum Tennessee Network	3,850	3,462	20	20
Others	1,384	1,073	4% – 50%	4% – 50%
	$ 32,019	31,976		

Wellmont provided billing and management services to the affiliates. Income recognized by Wellmont for the services was $1,766 in 2010 and $1,501 in 2009 and is included in other revenues.

Included in other receivables are $124 and $135 as of June 30, 2010 and 2009, respectively, of amounts due to Wellmont from these entities.

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

(Dollars in thousands)

(7) Investments

Long-term investments, including assets limited as to use, at June 30 are reported at fair value and consist of the following:

		2010	2009
Assets limited as to use by Board for capital improvements:			
Stock mutual funds	$	109,629	108,036
Bond mutual funds		71,698	5,910
Cash and money market funds		1,474	2,517
Real estate funds		7,468	5,419
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):			
Liquid		33,915	12,415
Illiquid		23,490	23,171
		247,674	157,468
Assets limited as to use under self-insurance agreements:			
Corporate bonds		6,867	7,464
Cash and money market funds		558	643
		7,425	8,107
Assets limited as to use under bond indenture agreements:			
Cash and money market funds		48,523	82,226
Less assets limited as to use that are required for current liabilities		1,815	2,201
Assets limited as to use, net of current portion	$	301,807	245,600
Long-term investments:			
Stock mutual funds	$	9,279	8,631
Bond mutual funds		7,599	3,648
Preferred equity investment and related options		11,512	11,512
Cash, money market funds, and certificates of deposit		287	5,202
Real estate funds		1,722	1,255
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):			
Liquid		1,992	1,726
Total long-term investments	$	32,391	31,974

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately $12,112 as of June 30, 2010 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which $417 was paid subsequent to June 30, 2010.

(Continued)

(Dollars in thousands)

Wellmont has invested $10,000 in the preferred equity of a regional managed services organization and $1,512 on a right of first refusal related to any future sale of this organization. This equity has a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

Wellmont's investments are concentrated in stock and bond mutual funds. In the event of a downward trend in the stock and bond markets, Wellmont's overall market value of net assets could be adversely affected by a material amount. Investments in alternative investments are generally illiquid investments whose value is determined by the general partner such as hedge funds, private equity, commingled funds, and real estate funds. Distributions are only at the discretion of a voting majority of the general partners.

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, the Company recognized other-than-temporary impairment losses of $8,233 and $4,654 on investments as of June 30, 2010 and 2009, respectively. The unrealized losses on these mutual funds were primarily caused by the overall decline in the world's economy in 2009 and 2010. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2010 and 2009, were as follows:

	June 30, 2010					
	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
Alternative investments	$ —	—	910	4,219	910	4,219
Stock mutual funds	2,184	29,658	24,817	83,713	27,001	113,371
	$ 2,184	29,658	25,727	87,932	27,911	117,590

	June 30, 2009					
	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
Bond mutual funds	$ 191	4,112	—	—	191	4,112
Alternative investments	5,525	16,227	4,144	7,120	9,669	23,347
Stock mutual funds	22,243	74,147	17,460	35,983	39,703	110,130
	$ 27,959	94,486	21,604	43,103	49,563	137,589

(Dollars in thousands)

Investment income is comprised of the following for the years ended June 30:

		2010	2009
Interest and dividends, net of amounts capitalized	$	5,330	9,717
Realized losses on investments, including $8,233 and $4,654 recognized losses related to other-than-temporary impairments in 2010 and 2009, respectively.		(4,318)	(5,536)
Investment income, net	$	1,012	4,181
Change in net unrealized gains (losses) on investments	$	22,312	(60,663)

(8) Land, Buildings, and Equipment

Land, buildings, and equipment at June 30 consist of the following:

		2010	2009
Land	$	41,210	44,149
Buildings and improvements		488,285	392,593
Equipment		327,896	303,805
Buildings and equipment under capital lease obligations		39,591	38,734
		896,982	779,281
Less accumulated depreciation		(459,935)	(418,399)
		437,047	360,882
Construction in progress		13,158	81,728
Land, buildings, and equipment	$	450,205	442,610

Depreciation expense for the years ended June 30, 2010 and 2009 was $43,755 and $43,393, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was $13,266 and $9,109 as of June 30, 2010 and 2009, respectively.

(Dollars in thousands)

(9) Other Long-Term Liabilities

Other long-term liabilities at June 30 consist of the following:

	2010	2009
Workers' compensation liability	$ 6,606	5,706
Professional and general liability	11,183	9,494
Postretirement benefit obligation	5,861	5,653
Asset retirement obligation	3,710	3,621
Deferred gain on sale of assets	1,382	2,136
Derivative liability	12,943	10,250
Pension benefit liability	10,018	6,709
Other	2,912	1,205
	54,615	44,774
Less current portion	(7,251)	(6,352)
Total other long-term liabilities	$ 47,364	38,422

(10) Lines of Credit/Notes Payable

During 2008, Wellmont entered into three lines of credit for $15,000, $1,800, and $10,000. The $15,000 line of credit had a variable interest rate based upon LIBOR plus 1% and a termination date of August 2009; at June 30, 2009, $14,000 was outstanding on this line. During 2010, the $15,000 line of credit was paid in full with a $14,000 note payable, which was initiated with one bank to pay off the line of credit. The $14,000 note payable has a variable interest rate based upon LIBOR plus 2% and a termination date of December 2010. At June 30, 2010, $14,000 was outstanding on this note. During 2008, a $1,800 line of credit was initiated with one bank and was paid in full with the funds from the $10,000 line of credit from another bank, which had variable interest rate based upon LIBOR plus 0.95% and a termination date of August 31, 2009; at June 30, 2010 and 2009, $0 and $1,811, respectively, was outstanding on this line. The $10,000 line of credit was paid in full in 2010.

(Dollars in thousands)

(11) Debt

(a) Long-Term Debt

Long-term debt consists of the following at June 30:

	2010	2009
Hospital Revenue Bonds, Series 2007A	$ 55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2006A and 2006B	93,405	95,205
Hospital Revenue Refunding Bonds, Series 2005	61,810	63,940
Hospital Revenue Bonds, Series 2003	36,666	40,145
Notes payable	6,429	4,399
Capital lease obligations	19,698	22,388
Other	358	71
	473,366	481,148
Unamortized premium	7,538	7,800
Unamortized discount	(1,113)	(1,143)
	479,791	487,805
Less current maturities	(11,958)	(13,197)
	$ 467,833	474,608

(b) Series 2007 Bonds

On July 24, 2007, The Virginia Small Business Financing Authority issued, on behalf of Wellmont, $55,000 of Hospital Revenue Bonds, Series 2007A. The Series 2007A Bonds, with other methods of financing, were used to purchase the assets of Mountain View Regional Medical Center and Lee Regional Medical Center.

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $360 to $2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of $29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.25%.

(c) Series 2006C

On October 26, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, $200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to: finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the

construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation, and equipping of an operating room and related facilities at HCMH.

Principal on outstanding Series 2006C Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,605 to $25,330 commencing on September 1, 2017 through September 1, 2036. The outstanding bonds accrue interest at rates ranging from 5.00% to 5.25%.

(d) Series 2006 A and B

On June 23, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, $98,475 of Hospital Revenue Refunding Bonds, Series 2006. This bond issuance consists of Series A tax-exempt and Series B taxable bonds of $76,595 and $21,880, respectively. The Series 2006 Bonds together with other available funds were used to advance refund all the previously issued Hospital Revenue Bonds, Series 1993, to reimburse Wellmont for payments made on other taxable borrowings and to pay certain expenses incurred in connection with the issuance of the Series 2006 Bonds. Upon this refunding, a trust was established to pay all future bond payments related to the Series 1993 Bonds. Wellmont was deemed to have paid the Series 1993 Bonds and these Bonds are no longer deemed to be outstanding for purposes of the Series 1993 Trust Indenture.

Principal on outstanding Series 2006A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $875 to $6,400 commencing on September 1, 2013 through September 1, 2032; and the outstanding bonds accrue interest on a variable rate, which is reset monthly based upon the AAA-insured Municipal Market Data Index, plus 85 basis points. Principal on outstanding Series 2006B Bonds is payable through maturity in annual amounts ranging from $1,600 to $2,930 commencing on September 1, 2007 through September 1, 2016, and the outstanding bonds accrue interest at a fixed rate of 6.95%.

Outstanding Series 2006A Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%–102% of the principal amount of the Series 2006A Bonds being redeemed, plus accrued interest thereon to the redemption date.

On October 1, 2010, the Series 2006B Bonds were called and paid in full at par value of $14,880.

(e) Series 2005

On December 8, 2005, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

Principal on outstanding Series 2005 Bonds is payable through maturity or scheduled mandatory sinking fund redemption in annual amounts ranging from $1,945 to $3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a "best efforts" basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. Subsequent to year-end, Wellmont amended its letter of credit to cover an amount equal to the principal and up to 40 days' interest on the bonds at a maximum interest rate of 12% per annum, and is effective through July 1, 2011. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate for the first 90 days equal to the greater of (i) the Prime Rate plus 1.50% per annum, ii) the Federal Funds Rate plus 3.00% per annum, or iii) 7.50% per annum. ; the Base Rate plus 0.50% for days 91 through 366 and the Base Rate plus 1.00% thereafter until the amount is paid in full.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%–102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(f) Series 2003

On June 1, 2003, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, $59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont's Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of $27,460 in fixed rate serial bonds and $19,280 in fixed rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from $3,230 on September 1, 2007 to $4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

(g) Master Trust Indenture

The master trust indenture and loan agreements for the 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their

obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

Funds held by the trustee related to the various revenue bonds are available for specific purposes. The bond interest and revenue funds may be used only to pay interest and principal on the bonds; the debt service reserve fund may be used to pay interest and principal if sufficient funds are not available in the bond interest and revenue funds. The original issue discount and premium on all Bond Series outstanding are being amortized over the life of the bond issue using the effective-interest method.

(h) Notes Payable

During 2007, Wellmont entered into a five-year $3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011; at June 30, 2010 and 2009, $2,062 and $2,319, respectively, was outstanding on this note.

During 2008, Wellmont entered into a five-year $2,400 term note payable, which has a fixed interest rate of 7.25% and a termination date of August 2012; at June 30, 2010 and 2009, $1,600 and $2,080, respectively, was outstanding on this note.

During 2010, Wellmont entered into a $2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable has a fixed interest rate of 5.5% and a termination date of May 2013. At June 30, 2010, $2,767 was outstanding on this note.

(i) Capital Lease Obligations

Wellmont has entered into leases for certain equipment under agreements classified as capital leases that expire over periods through 2011. Assets under capital leases are included in property and equipment and have a net carrying value of $26,325 and $29,625 as of June 30, 2010 and 2009, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 4.3% to 6.0%.

(Dollars in thousands)

(j) Long-term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2010 are as follows:

2011	$	11,958
2012		13,329
2013		12,935
2014		12,193
2015		12,415
Thereafter		410,536
	$	473,366

The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2011	$	11,958
2012		30,859
2013		30,365
2014		29,508
2015		9,755
Thereafter		360,921
	$	473,366

Interest paid for the years ended June 30, 2010 and 2009 was $20,792 and $21,564, respectively, net of amounts capitalized. Interest costs of $2,776 and $3,421, net of interest income of $683 and $3,293 in 2010 and 2009, respectively, were capitalized.

(12) Derivative Transactions

Interest Rate Swaps: Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to postcollateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and

(Dollars in thousands)

Wellmont's bond rating. As of June 30, 2010 and 2009, Wellmont was not required to postcollateral related to its swaps.

Market risk is the adverse effect on the value of a derivative instrument that results from a change in interest rates. The market risk associated with interest-rate contracts is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

In September and October 2008, the counterparty and credit support provider to the swaps filed bankruptcy. Subsequent to the bankruptcy filings, no payments have been made by Wellmont or the counterparty to each other. As of June 30, 2010, the net amounts due to Wellmont for this period are less than $100 and have been fully reserved. The bankruptcy process is underway and the outcome cannot be determined at this time.

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its debt structure using LIBOR. The fair value as of June 30, 2010 and 2009 of approximately $(12,943) and $(10,250), respectively, is included in other liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately $(2,693) and $(5,747), respectively, in 2010 and 2009 and is included in nonoperating losses, net in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The net amounts have been recorded pending the outcome of any bankruptcy proceedings. The following is a summary of the interest rate swap information as of June 30, 2010:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2006A	$ 76,595	June 29, 2006	September 1, 2011	1.103%	5.440%	$ 1,101
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.217	(6,810)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	0.253	0.198	(2,710)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	0.162	(4,524)
							$ (12,943)

The following is a summary of the interest rate swap information as of June 30, 2009:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2006A	$ 76,595	June 29, 2006	September 1, 2011	2.744%	5.884%	$ 1,075
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.309	(5,197)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	1.894	1.728	(2,708)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	1.184	(3,420)
							$ (10,250)

(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was $9,990 and $9,937 for the years ended June 30, 2010 and 2009, respectively.

HVMC sponsored a noncontributory, defined benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined benefit pension plan covering substantially all its employees.

HVMC's defined pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined pension plan exists. Collectively, the two defined benefit plans are referred to as the "Plans."

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined benefit pension plans as an asset or liability in its consolidated balance sheets and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined benefit pension plans use a June 30 measurement date.

(Continued)

(Dollars in thousands)

The following table sets forth the funded status of the combined Plans, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		2010	2009
Change in benefit obligation:			
Benefit obligation at beginning of year	$	40,035	37,212
Service cost		230	234
Interest cost		2,432	2,441
Actuarial losses		4,008	2,132
Benefits paid		(2,140)	(1,984)
Benefit obligation at end of year	$	44,565	40,035
Change in plan assets:			
Fair value of plan assets at beginning of year		33,326	43,420
Actual return on plan assets		3,361	(8,110)
Benefits paid		(2,140)	(1,984)
Fair value of plan assets at end of year		34,547	33,326
Funded status	$	(10,018)	(6,709)
Amounts recognized in the accompanying consolidated balance sheets:			
Pension liability – other long-term liability	$	(10,018)	(6,709)

(Continued)

(Dollars in thousands)

		2010	2009
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:			
Unrecognized actuarial loss	$	13,158	10,851
Unrecognized prior service cost		2	2
Net amounts included as an accumulated charge to unrestricted net assets	$	13,160	10,853
Calculation of change in unrestricted net assets:			
Accumulated charge to unrestricted net assets, end of year	$	13,160	10,853
Reversal of accumulated credit to unrestricted net assets, prior year		(10,853)	2,357
Change in unrestricted net assets	$	2,307	13,210
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Actuarial loss arising during the year	$	2,907	13,210
Amortization of actuarial gain or loss		(600)	—
Amortization of prior service cost		—	—
Net amounts recognized as a charge to unrestricted net assets	$	2,307	13,210

(Continued)

(Dollars in thousands)

		2010	2009
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2011:			
Amortization of net loss	$	791	—
Amortization of prior service cost		—	2
Estimated future benefit payments:			
Fiscal 2011		2,211	2,150
Fiscal 2012		2,220	2,189
Fiscal 2013		2,337	2,314
Fiscal 2014		2,472	2,456
Fiscal 2015 (FY09 fiscal 2015 – 2019)		2,578	13,769
Fiscal 2016 – 2020		14,278	
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		5.50%	6.25%
Weighted average rate of increase in future compensation levels		3.00	3.00
Components of net periodic benefit cost (benefit):			
Service cost	$	230	234
Interest cost		2,432	2,441
Expected return on plan assets		(2,259)	(2,968)
Amortization of unrecognized net loss		600	—
Amortization of unrecognized prior service cost		—	0
Net periodic benefit cost (benefit)	$	1,003	(293)
Weighted average assumptions used to determine net periodic benefit cost:			
Settlement (discount) rate		6.25%	6.75%
Expected long-term return on plan assets (HVMC)		7.00	7.00
Expected long-term return on plan assets (LPH)		7.00	7.00
Weighted average rate of increase in future compensation levels		3.00	3.00

Wellmont's overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont does not expect to make any contributions to the Plans during 2011.

Wellmont has developed a plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such

(Dollars in thousands)

categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

The table below shows the target allocation and actual asset allocations as of June 30, 2010 and 2009:

Asset	Target allocation	June 30, 2010	June 30, 2009
Equity securities	65%	56%	53%
Fixed income	28	27	29
Cash	5% – 15%	1	3
Other	5 – 15	16	15

Wellmont monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

HVMC also participates in a health and welfare plan for its retirees. The plan provides postretirement medical and life insurance benefits to certain employees who meet minimum age and service requirements. Effective January 1, 1995, the death benefit was changed to provide a flat $5 benefit to all future retirees. During 1995, the medical program for retirees was amended to terminate medical benefits for any active employees who would not meet the full eligibility requirements of the program by January 1, 1996. The plan is contributory and contains other cost-sharing features such as deductibles and coinsurance.

(Dollars in thousands)

The following table sets forth the postretirement plan's funded status, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		2010	2009
Change in benefit obligation:			
Benefit obligation at beginning of year	$	5,653	5,637
Interest cost		320	355
Plan participants contributions		73	36
Actuarial losses		197	23
Benefits paid		(382)	(398)
Benefit obligation at end of year		5,861	5,653
Change in plan assets:			
Fair value of plan assets at beginning of year		—	—
Employer contribution		309	362
Plan participants contributions		73	36
Benefits paid		(382)	(398)
Fair value of plan assets at end of year		—	—
Funded status	$	(5,861)	(5,653)
Amounts recognized in the consolidated balance sheets consist of:			
Noncurrent liaibilities	$	(5,861)	(5,653)
Accumulated credit to unrestricted net assets		3,560	4,076
	$	(2,301)	(1,577)

Amounts recognized as an accumulated credit to unrestricted net assets consist of:

		Postretirement benefits	
		2010	2009
Net actuarial gain	$	3,560	4,076

(Continued)

(Dollars in thousands)

Net periodic benefic cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2010 and 2009 were:

	Postretirement benefits	
	2010	**2009**
Net periodic benefit cost:		
Interest cost	$ 320	355
Amortization of net gain	(319)	(335)
Net periodic benefit cost recognized	1	20
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	197	23
Amortization of net gain	319	335
Total recognized as a charge to unrestricted net assets	516	358
Total recognized in net periodic benefit cost and unrestricted net assets	$ 517	378

The net gain and prior service credit for the defined benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $(261) and $0, respectively. Weighted average assumptions used to determine benefit obligations for 2010 and 2009 were as follows:

	Postretirement benefits	
	2010	**2009**
Discount rate	5.00%	6.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2010 and 2009 were as follows:

	Postretirement benefits	
	2010	**2009**
Discount rate	6.00%	6.75%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00%	5.00%

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

(Continued)

(Dollars in thousands)

For measurement purposes, a 5% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2010.

The following table summarizes the effect of one-percentage-point increase/decrease in healthcare costs trends:

	2010	2009
Effect of one-percentage-point increase in healthcare cost trend on:		
Service and interest cost	$ 20	22
Accumulated pension benefit obligation	330	326
Effect of one-percentage-point decrease in healthcare cost trend on:		
Service and interest cost	(18)	(20)
Accumulated pension benefit obligation	(294)	(291)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2010 and 2009, respectively, were as follows:

	Fair value measurement at June 30, 2010 pension benefits – plan assets			
Asset category	**Total**	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Stock mutual funds	$ 28,803	19,412	9,391	—
Cash and money market funds	244	244	—	—
Alternative investments	5,500	—	—	5,500
Total	$ 34,547	19,656	9,391	5,500

(Continued)

(Dollars in thousands)

Asset category	Total	Fair value measurement at June 30, 2009 pension benefits − plan assets: Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Stock mutual funds	$ 27,444	17,710	9,734	—
Cash and money market funds	749	749	—	—
Alternative investments	5,133	—	—	5,133
Total	$ 33,326	18,459	9,734	5,133

The following tables presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2010 and 2009:

	Alternative investments
Balance at June 30, 2008	$ 7,960
Net change in value	(4,464)
Purchases, issuances, and settlements	1,637
Tranfers in and/or out of Level 3 (net)	—
Balance at June 30, 2009	5,133
Net change in value	254
Purchases, issuances, and settlements	113
Tranfers in and/or out of Level 3 (net)	—
Balance at June 30, 2010	$ 5,500

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers' compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont has established revocable self-insurance trust funds to provide for professional and general liability claims and workers' compensation claims and related expenses. Wellmont's contributions to the self-insurance trusts are based upon actuarial determinations by an independent service company. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Wellmont does not

(Dollars in thousands)

qualify as a self-insurer in Kentucky and hence purchases a separate policy for its operation in Kentucky. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Insurance expense under these programs amounted to approximately $3,414 and $5,658 for the years ended June 30, 2010 and 2009, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2010 and 2009, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2010 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2010 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

Wellmont is also self-insured for medical and other healthcare benefits provided to its employees and their families. A provision for estimated incurred but not reported claims has been provided in the consolidated financial statements.

(15) Commitments and Contingencies

Construction in progress at June 30, 2010 and 2009 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately $11,920 at June 30, 2010. Wellmont has entered into contracts of approximately $11,920 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was $16,857 and 16,441 for the years ended June 30, 2010 and 2009, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2010 are as follows:

2011	$	14,227
2012		12,318
2013		8,149
2014		3,763
2015		3,383
Thereafter		20,699
	$	62,539

The HCHM lease to WHCMH is for 20 years and can be automatically extended for two additional terms of 10 years each. Should WHCMH generate annual net excess revenue over expenses, 50% shall be transferred to a designated fund in the Foundation for the purpose of healthcare projects. No transfers were required for the years ended June 30, 2010 and 2009.

(Dollars in thousands)

Wellmont has entered into contractual employment relationships with physicians to provide services to Wellmont physician practices that are intended to qualify under the employee safe harbor of the Anti-Kickback Statute and the employee exception of the Physician Self-Referral Law. These contracts have terms of varying lengths, guarantee certain base payments, and may provide for additional incentives based upon productivity.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, such matters as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes Wellmont is in compliance with fraud and abuse statutes and other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

(16) Functional Expense Disclosure

Wellmont provides healthcare services to residents within its geographic location. Expenses based upon functional classification related to providing these services during the years ended June 30 are as follows:

		2010	2009
Professional care of patients	$	605,360	617,198
Administrative and general		117,123	101,641
Fund-raising		1,235	1,260
	$	723,718	720,099

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately $52,000 at June 30, 2010, which begin expiring in fiscal 2016 and expire through 2030. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately $975 for unrelated business activities. Management believes that it is not more likely than not that deferred tax assets arising from net operating loss carryforwards will be realizable. Accordingly, these are fully reserved at June 30, 2010 and 2009.

(Continued)

(Dollars in thousands)

(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2010 and 2009 was as follows:

	2010	2009
Medicare	46%	45%
TennCare	4	4
Medicaid	8	8
Other third-party payors	31	31
Patients	11	12
	100%	100%

(19) Disclosures about Fair Value of Financial Instruments

(a) Fair Value of Financial Instruments

The following methods and assumptions were used to estimate fair value of each class of instruments:

Cash and Cash Equivalents

The carrying amount approximates fair value due to the short maturities of these instruments.

Patient Accounts and Other Receivables

The net recorded carrying value approximates fair value due to the short maturities of these instruments.

Investments and Assets Limited as to Use

The fair values of investments and assets limited as to use are based on quoted market prices and quotes obtained from security brokers or, in the case of the limited partnerships, by the general partner.

Accounts Payable and Accrued Expenses

The carrying amount approximates fair value due to the short maturities of these liabilities.

Estimated Third-Party Payor Settlements, Other Long-Term Liabilities

The carrying amount approximates fair market value due to the nature of these liabilities.

Long-Term Debt

The fair value of revenue bonds, using current market rates, was estimated at $422,290 and $344,863 for the years ended June 30, 2010 and 2009, respectively.

(b) Fair Value Hierarchy

On July 1, 2008, Wellmont adopted new guidance issued by FASB for fair value measurement of financial assets and financial liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis now codified into ASC 820, *Fair Value Measurements and Disclosures*. ASC 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date.

- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair value measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

In conjunction with the adoption of the new guidance, Wellmont elected to early adopt the measurement provisions of Accounting Standards Update No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was $56,972 and $37,312 at June 30, 2010 and 2009, respectively.

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2010:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 35,711	—	—	35,711
Assets limited as to use:				
Stock mutual funds	109,629	—	—	109,629
Bond mutual funds	71,698	—	—	71,698
Cash and money market funds	50,555	—	—	50,555
Real estate funds	7,468	—	—	7,468
Alternative investments		18,043	39,362	57,405
Corporate bonds	6,867	—	—	6,867
	246,217	18,043	39,362	303,622
Long-term investments:				
Stock mutual funds	9,279	—	—	9,279
Bond mutual funds	7,599	—	—	7,599
Cash and money market funds	287	—	—	287
Real estate funds	1,722	—	—	1,722
Alternative investments	—	1,992	—	1,992
	18,887	1,992	—	20,879
Total assets	$ 300,815	20,035	39,362	360,212
Liabilities:				
Interest rate derivatives liability	$ —	12,943	—	12,943
Total liability	$ —	12,943	—	12,943

(Continued)

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2009:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 60,889	—	—	60,889
Assets limited as to use:				
Stock mutual funds	108,036	—	—	108,036
Bond mutual funds	5,910	—	—	5,910
Cash and money market funds	85,386	—	—	85,386
Real estate funds	5,419	—	—	5,419
Alternative investments		2,295	33,291	35,586
Corporate bonds	7,464	—	—	7,464
	212,215	2,295	33,291	247,801
Long-term investments:				
Stock mutual funds	8,631	—	—	8,631
Bond mutual funds	3,648	—	—	3,648
Cash and money market funds	5,202	—	—	5,202
Real estate funds	1,255	—	—	1,255
Alternative investments	—	1,726	—	1,726
	18,736	1,726	—	20,462
Total assets	$ 291,840	4,021	33,291	329,152
Liabilities:				
Interest rate derivatives liability	$ —	10,250	—	10,250
Total liability	$ —	10,250	—	10,250

(Continued)

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2010 and 2009:

		Alternative investments
Balance at June 30, 2008:	$	51,661
Total realized and unrealized gains (losses):		
Included in revenues and gains in excess of expenses and losses		—
Included in changes in net assets		(3,574)
Purchases, issuances, and settlements		(14,796)
Transfers in and/or out of Level 3 (net)		—
Balance at June 30, 2009:	$	33,291
Total realized and unrealized gains (losses):		
Included in revenues and gains in excess of expenses and losses		—
Included in changes in net assets		469
Purchases, issuances, and settlements		5,602
Transfers in and/or out of Level 3 (net)		—
Balance at June 30, 2010	$	39,362

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2011 and 2010

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

Table of Contents

KPMG LLP
Suite 1000
401 Commerce Street
Nashville, TN 37219-2422

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

We have audited the accompanying consolidated balance sheets of Wellmont Health System and affiliates (Wellmont) as of June 30, 2011 and 2010, 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 Wellmont'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 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 Wellmont's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that 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 consolidated financial position of Wellmont Health System and affiliates as of June 30, 2011 and 2010, and the consolidated results of their operations and changes in net assets, and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

October 27, 2011

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2011 and 2010

(Dollars in thousands)

Assets		2011	2010
Current assets:			
Cash and cash equivalents	$	36,558	35,711
Assets limited as to use, required for current liabilities		1,902	1,815
Patient accounts receivable, less allowance for uncollectible accounts of approximately $24,246 and $25,113 in 2011 and 2010, respectively		101,565	94,057
Other receivables		9,904	10,919
Inventories		17,830	18,294
Prepaid expenses and other current assets		7,163	7,003
Total current assets		174,922	167,799
Assets limited as to use, net of current portion		319,387	301,807
Land, buildings, and equipment, net		454,937	450,205
Other assets:			
Long-term investments		36,437	32,391
Investments in affiliates		31,177	32,019
Deferred debt expense, net		5,847	4,644
Goodwill		16,721	9,501
Other		1,875	730
		92,057	79,285
Total assets	$	1,041,303	999,096
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	9,273	11,958
Short-term note payable		—	14,000
Accounts payable and accrued expenses		70,943	74,679
Estimated third-party payor settlements		9,533	11,672
Current portion of other long-term liabilities		8,527	7,251
Total current liabilities		98,276	119,560
Long-term debt, less current portion		459,260	467,833
Other long-term liabilities, less current portion		42,006	44,976
Total liabilities		599,542	632,369
Net assets:			
Unrestricted		434,661	358,620
Temporarily restricted		3,570	4,551
Permanently restricted		1,174	1,168
Total net assets attributable to Wellmont		439,405	364,339
Noncontrolling interests		2,356	2,388
Total net assets		441,761	366,727
Commitments and contingencies			
Total liabilities and net assets	$	1,041,303	999,096

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2011 and 2010

(Dollars in thousands)

	2011	2010
Revenue:		
Net patient service revenue	$ 767,450	692,920
Other revenues	29,799	31,472
Total revenue	797,249	724,392
Expenses:		
Salaries and benefits	347,185	310,667
Medical supplies and drugs	160,565	150,143
Purchased services	80,348	74,922
Interest	20,750	20,110
Provision for bad debts	37,858	35,293
Depreciation and amortization	46,059	43,711
Other	87,319	66,734
Total expenses	780,084	701,580
Income from operations	17,165	22,812
Nonoperating gains (losses):		
Investment income	10,383	1,012
Derivative valuation adjustments	1,355	(2,693)
Other, net	(519)	(805)
Gain on refinancing	1,042	—
Nonoperating gains (losses), net	12,261	(2,486)
Revenue and gains in excess of expenses and losses before discontinued operations	29,426	20,326
Discontinued operations	44	(1,109)
Revenue and gains in excess of expenses and losses	29,470	19,217
Income attributable to noncontrolling interests	(1,238)	(1,062)
Revenues and gains in excess of expenses and losses attributable to Wellmont	28,232	18,155
Other changes in unrestricted net assets:		
Change in net unrealized gains on investments	42,186	22,312
Net assets released from restrictions for additions to land, buildings, and equipment	2,852	1,555
Change in the funded status of benefit plans and other	2,771	(3,428)
Increase in unrestricted net assets	76,041	38,594
Changes in temporarily restricted net assets:		
Contributions	2,566	2,934
Net assets released from temporary restrictions	(3,547)	(1,972)
(Decrease) increase in temporarily restricted net assets	(981)	962
Changes in permanently restricted net assets – investment income (loss)	6	(77)
Changes in noncontrolling interests:		
Adjustment due to adoption of authoritative guidance	—	2,054
Income attributable to noncontrolling interests	1,238	1,062
Distributions to noncontrolling interests	(1,178)	(711)
Change in noncontrolling percentages	(92)	(21)
(Decrease) increase in noncontrolling interests	(32)	2,384
Change in net assets	75,034	41,863
Net assets, beginning of year	366,727	324,864
Net assets, end of year	$ 441,761	366,727

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2011 and 2010

(Dollars in thousands)

	2011	2010
Cash flows from operating activities:		
Change in net assets	$ 75,034	41,863
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	46,070	43,755
(Gain) loss on disposal of land, buildings, and equipment	(864)	1,282
Equity in earnings of affiliated organizations	(4,478)	(6,773)
Distributions from affiliated organizations	5,320	6,730
Amortization of deferred financing costs	158	180
Net realized and unrealized gains on investments	(43,162)	(17,994)
Provision for bad debts	37,893	35,950
Change in fair value of derivative instruments	(1,355)	2,693
Gain on refinancing	(1,042)	—
Changes in assets and liabilities:		
Patient accounts receivable	(45,402)	(31,936)
Other current assets	303	(2,088)
Other assets	(538)	322
Accounts payable and accrued expenses	(6,729)	2,722
Estimated third-party payor settlements	(2,139)	(769)
Other current liabilities	1,276	899
Other liabilities	(63)	5,545
Net cash provided by operating activities	60,282	82,381
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	186,085	88,887
Purchase of investments	(164,635)	(127,131)
Purchase of land, buildings, and equipment	(42,352)	(55,684)
Proceeds from the sale of buildings and equipment	244	4,357
Cash paid for acquisitions	(7,826)	(2,421)
Distributions to affiliated organizations	—	(1,684)
Net cash used in investing activities	(28,484)	(93,676)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	91,133	14,000
Payments on long-term debt	(106,069)	(12,083)
Payment of debt issuance costs	(2,015)	—
Payments on line of credit	(14,000)	(15,800)
Net cash used in financing activities	(30,951)	(13,883)
Net increase (decrease) in cash and cash equivalents	847	(25,178)
Cash and cash equivalents, beginning of year	35,711	60,889
Cash and cash equivalents, end of year	$ 36,558	35,711

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of $5,785 and $1,290 in 2011 and 2010, respectively.

Additions to property and equipment financed through current liabilities of $2,933 and $5,182 in 2011 and 2010, respectively.

See accompanying notes to consolidated financial statements.

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont) was formed to assume operations of Bristol Regional Medical Center (BRMC) and Holston Valley Health Care, Inc. (HVHC), including Holston Valley Medical Center, Inc. (HVMC), and to act as sole corporate member of its consolidated foundations. Effective July 1, 1996, under terms of an agreement and plan of consolidation and merger, BRMC and HVHC, including HVMC, were merged and consolidated into Wellmont. Effective January 1, 1997, Lonesome Pine Hospital (LPH), a Virginia corporation, was merged into Wellmont under terms of a plan of merger and merger agreement. Effective July 1, 2000, Hawkins County Memorial Hospital (HCMH) transferred its operations and operating assets to Wellmont Hawkins County Memorial Hospital (WHCMH), a tax-exempt organization that is wholly owned and controlled by Wellmont. Hancock County Hospital (HCH), a critical access hospital, was opened in March 2005 to help provide for the immediate healthcare needs of the residents of Sneedville and the surrounding counties. As of July 16, 2007, Wellmont acquired Jenkins Community Hospital in Kentucky. As of August 1, 2007, Wellmont acquired two hospitals in Virginia, Lee Regional Medical Center in Pennington Gap and Mountain View Regional Medical Center in Norton. On May 30, 2008, Wellmont acquired the Holston Valley Cath Lab, an outpatient lab. On May 1, 2010, Wellmont acquired Cardiovascular Associates. On January 1, 2011 Wellmont acquired Pulmonary Associates of Kingsport.

As of April 30, 2009, Wellmont closed Jenkins. The consolidated financial statements for the years ended June 30, 2011 and 2010 present Jenkins as a discontinued operation. Losses of $120 and $474 for the years ended June 30, 2011 and June 30, 2010, respectively, are included in discontinued operations.

As of September 23, 2010 Wellmont sold the majority of Medical Mall Pharmacy's assets to a national pharmacy company for $1,300 plus inventory value and recorded a gain of approximately $517 at June 30, 2011. The consolidated financial statements for the years ended June 30, 2011 and 2010 present Medical Mall Pharmacy as a discontinued operation. Losses of $353 and $635 for the years ended June 30, 2011 and June 30, 2010, respectively, are included in discontinued operations.

All acute care operations remain separately licensed and are treated as operating divisions within Wellmont. Wellmont's continuing operations consist primarily of the delivery of healthcare services in northeast Tennessee, and southwest Virginia.

The consolidated financial statements include the acute care operations of the above entities along with:

- Wellmont Foundation (the Foundation), which was created from the merger of Bristol Regional Medical Center Foundation and Holston Valley Health Care Foundation, Inc. The Foundation conducts fund-raising activities for the benefit of Wellmont.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

- The Alzheimer's Center of East Tennessee was merged into Wellmont and changed its name to Wellmont Madison House effective September 1, 1997. Wellmont is the sole corporate member and the consolidated financial statements include the operations of this entity.

All significant intercompany accounts and transactions have been eliminated in the accompanying consolidated financial statements.

(2) Significant Accounting Policies

A summary of significant accounting policies follows:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) 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. Significant estimates include: allowances for contractual adjustments and bad debts; third-party payor settlements; valuation of investments, land, buildings, equipment and goodwill; and self-insurance and other liabilities. Actual results could differ from these estimates.

(b) Cash and Cash Equivalents

Wellmont considers all highly liquid investments with a maturity of three months or less when purchased, excluding amounts whose use is limited by board of director's designation or other arrangements under trust agreements, to be cash equivalents.

(c) Investments

Marketable equity securities and debt securities are recorded at fair value and classified as other than trading. Fair value is determined primarily using quoted prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date. However, Wellmont also uses observable and unobservable inputs for investments without quoted market prices to determine the fair value of certain investments at the measurement date. Investments in limited partnerships are recorded at fair value as determined by the partnership using net asset value. Wellmont has adopted the measurement provisions of Accounting Standards Update No. 2009-12, *Investments in certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. Investments in affiliates in which Wellmont has significant influence but does not control are reported on the equity method of accounting, which represents Wellmont's equity in the underlying net book value. Long-term investments include those investments that have not been designated by the board of directors for specific purposes and are also not intended to be used for the liquidation of current liabilities. Investment income is recognized when earned.

Realized gains and losses are determined on the specific-identification method and included in investment income with interest and dividends. Investment income is reported net of related investment fees. Unrealized gains and losses are included in other changes in unrestricted net assets except for losses determined to be other than temporary, which are considered realized losses and included in investment income.

(d) Assets Limited as to Use

Assets limited as to use primarily include assets held by trustees under bond indenture and self-insurance agreements, as well as designated assets set aside by the board of directors for future capital improvements, over which the board of directors retains control and may, at its discretion, subsequently use for other purposes. Amounts required to meet current liabilities of Wellmont have been reclassified to current assets in the accompanying consolidated balance sheets.

(e) Inventories

Inventories are stated at the lower of cost or market value and are valued principally by the first-in, first-out and average-cost methods.

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, if purchased, or fair value at date of donation. Depreciation is computed using the straight-line method based on the estimated useful life of the asset, ranging from 3 to 40 years. Buildings and equipment held under capital leases are recorded at net present value of future lease payments and are amortized on a straight-line basis over the shorter of the lease term or estimated useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Upon sale or retirement of land, buildings, or equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss, if any, is included in other revenues on the consolidated statements of operations and changes in net assets. 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.

Wellmont evaluates long-lived assets for impairment on annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset.

(Dollars in thousands)

(g) Goodwill

Effective July 1, 2010, Wellmont adopted ASU 2010-07 which in part requires healthcare entities to follow ASC Topic 350-20-35, *Intangibles – Goodwill and Other*. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. The goodwill impairment test is a two-step test. Under the first step, the fair value of each reporting unit is compared with its carrying value (including goodwill). If the fair value of a reporting unit is less than its carrying value, an indication of goodwill impairment exists for the reporting unit and the entity must perform step two of the impairment test (measurement). Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. Wellmont has determined that the appropriate reporting unit for goodwill is the consolidated Wellmont entity and the annual impairment test is performed as of June 30. A summary of goodwill and related amortization for the year ended June 30 follows:

		2010	Additions	Decreases	2011
Goodwill	$	9,501	7,220	—	16,721

		2009	Additions	Decreases	2010
Goodwill	$	12,604	—	—	12,604
Amortization		(3,095)	(8)	—	(3,103)
	$	9,509	(8)	—	9,501

(h) Deferred Debt Expense

Deferred debt expense is amortized over the life of the related bond issues using the effective-interest method.

(i) Derivative Financial Instruments

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations

and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) Asset Retirement Obligations

Asset retirement obligations (AROs) are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value, and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, Wellmont records period-to-period changes in the ARO liability resulting from the passage of time and revisions to either the timing or the amount of the original estimate of undiscounted cash flows. Wellmont derecognizes ARO liabilities when the related obligations are settled.

(k) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by Wellmont has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by Wellmont in perpetuity. Generally, donors of permanently restricted assets permit use of all or part of the income earned on related investments for general or specific purposes.

Temporarily restricted net assets relate primarily to amounts held by the Foundation and include amounts restricted for future capital expenditures and for operations of such areas as children's healthcare services, hospice, and cancer research.

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2011 and 2010 primarily included amounts related to the purchase of buildings and equipment for pediatrics, cancer, and other healthcare operations.

Wellmont has adopted guidance issued by FASB, which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA). Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of four individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or

accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

Patient accounts receivable are reported net of both an allowance for contractual adjustments and an allowance for uncollectible accounts. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, TennCare, Medicaid, and other third-party payment programs. Wellmont's policy does not require collateral or other security for patient accounts receivable. Wellmont routinely obtains assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans, or policies.

(m) Revenue and Gains in Excess of Expenses and Losses

The consolidated statements of operations and changes in net assets include revenue and gains in excess of expenses and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include changes in net unrealized gains (losses) on investments other than trading securities, changes in the funded status of Wellmont's defined benefit plan, contributions of long-lived assets, including assets acquired using contributions that, by donor restriction, were to be used for the purposes of acquiring such assets, and cumulative effects of changes in accounting principles.

For purposes of financial statement display, those activities directly associated with Wellmont's mission of providing healthcare services are considered to be operating activities. Nonoperating activities primarily include investment and related activities. Other operating revenues primarily include cafeteria, rental, and income from affiliates.

(n) Contributed Resources

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted contributions, and are excluded from revenue and gains in excess of expenses and loses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets

with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. Gifts are reported as either a temporarily or permanently restricted contribution if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions. Unrestricted contributions are included in other revenues.

(o) Federal Income Taxes

The Wellmont entities are primarily classified as organizations exempt from federal income taxes under Section 501(a) as entities described in Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been included for these entities in the consolidated financial statements. The operations of Wellmont, Inc. are subject to state and federal income taxes, which are accounted for in accordance with ASC 740, *Income Taxes*; however, such amounts are not material.

On July 1, 2007, Wellmont adopted new guidance issued on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

(p) New Accounting Pronouncements

Effective July 1, 2010, Wellmont adopted the new provisions of ASC 810-10-65-1 regarding noncontrolling interests in consolidated financial statements. This guidance requires Wellmont to clearly identify and present ownership interest in subsidiaries held by parties other than Wellmont in the consolidated financial statements within the net assets section. It also requires the amounts of consolidated revenues and gains in excess of expenses and losses attributable to Wellmont and to the noncontrolling interest to be clearly identified and presented on the face of the consolidated statements of operations. Upon adoption, Wellmont recorded a reclassification of $2,054 to reclass noncontrolling interest to net assets as of July 1, 2009.

In January 2010, the Financial Accounting Standards Board issued ASU 2010-06, *Improving Disclosures about Fair Value Measurements* (ASU 2010-06). ASU 2010-06 amends ASC Subtopic 820-10, Fair Value Measurements and Disclosures, to provide additional disclosure requirements for transfers into and out of Levels 1 and 2 and for activity in Level 3 and to clarify

other existing disclosure requirements. WHS implemented ASU 2010-06 for the period ended June 30, 2011.

In January 2010, the Financial Accounting Standards Board issued ASU 2010-07, *Not-for-Profit Entities: Mergers and Acquisitions* (ASU 2010-07). ASU 2010-07 provides guidance on a transaction or other event in which a not-for-profit entity that is a reporting entity combines with one or more other not-for-profit, businesses or nonprofit activities in a transaction that meets the definition of a merger of not-for-profit entities or an acquisition by a not-for-profit entity. In addition the ASU provides transitional guidance on existing goodwill at the time this ASU is adopted. WHS adopted ASU 2010-07 effective July 1, 2010.

In August 2010, the Financial Accounting Standards Board issued ASU 2010-23, *Measuring Charity Care for Disclosure* (ASU 2010-23). ASU 2010-23 requires that cost be used as the measurement basis for charity care disclosures purposes and that cost can be identified as direct and indirect costs of providing charity care. The adoption of ASU 2010-23 will be effective for WHS beginning in fiscal year 2012.

In August 2010, the Financial Accounting Standards Board issued ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24). ASU 2010-24 clarifies that healthcare entities should not net insurance recoveries against the related claim liability and that the claim liability amount should be determined without consideration of insurance recoveries. The adoption of ASU 2010-24 will be effective for WHS beginning in fiscal year 2012.

In July 2011, the Financial Accounting Standards Board issued ASU 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07). ASU 2011-07 will change WHS' presentation of provision for bad debts in the consolidated statements of operations and changes in net assets to a deduction from net patient service revenue. In addition there are enhanced disclosures about the entities policies for recognizing revenue and assessing bad debts. The ASU also requires disclosures of patient service revenue as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. The adoption of ASU 2011-07 will be effective for WHS beginning in fiscal year 2013 with early adoption permitted.

(q) Reclassifications

Certain 2010 amounts have been reclassified to conform to the 2011 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

(Dollars in thousands)

(3) 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 consolidated statements of operations and changes in net assets is as follows for the years ended June 30:

		2011	2010
Gross patient service charges	$	2,260,489	2,158,847
Less:			
Contractual adjustments and other discounts		(1,431,215)	(1,411,435)
Charity care		(61,824)	(54,492)
		(1,493,039)	(1,465,927)
Net patient service revenue	$	767,450	692,920

(4) Third-Party Reimbursement Arrangements

Wellmont renders services to patients under contractual arrangements with the Medicare and Medicaid programs. The Medicaid program in Tennessee was replaced with a managed care program known as TennCare, which was designed to cover previous Medicaid eligible enrollees. Amounts earned under these contractual arrangements are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Management believes that adequate provision has been made for any adjustments that may result from such reviews. Participation in these programs subjects Wellmont to significant rules and regulations; failure to adhere to such could result in fines, penalties, or expulsion from the programs.

Wellmont contracts with various managed care organizations under the TennCare program. TennCare reimbursement for both inpatient and outpatient services is based upon prospectively determined rates, including diagnostic-related group assignments, fee schedules and per diem amounts. Reimbursement under the Virginia Medicaid program is also based upon prospectively determined amounts.

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid-eligible and other low-income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

(Continued)

(Dollars in thousands)

Net patient service revenue in 2011 and 2010 related to Medicare, TennCare and Virginia Medicaid and net patient accounts receivable at June 30, 2011 and 2010 from Medicare, TennCare, and Virginia Medicaid were as follows:

		2011	2010
Net patient service revenue:			
Medicare	$	286,977	277,372
TennCare		23,575	22,918
Virginia Medicaid		22,555	23,536
Net patient accounts receivable:			
Medicare	$	34,671	41,125
TennCare		2,798	2,206
Virginia Medicaid		3,427	3,739

Wellmont has filed cost reports with Medicare and Virginia Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Virginia Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2006 and audit adjustments have been received and considered for certain hospital and year-ends through June 30, 2010.

Wellmont has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, per diem rates, and discounts from established charges.

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately $2,319 and $863 in 2011 and 2010, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2011 could differ materially from actual settlements based on the results of third-party audits.

(5) Charity Care and Community Services

Wellmont accepts all patients within its primary service area regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies that consider, among other factors, generally recognized poverty income levels.

Wellmont maintains records to identify and monitor the level of charity care it provides. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and

(Dollars in thousands)

the equivalent percentage of charity care patients to all patients serviced were $61,824, $18,080, and 2.73%, respectively, for the year ended June 30, 2011 and $54,492, $15,567, and 2.52%, respectively, for the year ended June 30, 2010.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled $56,658 and $55,461 for the years ended June 30, 2011 and 2010, respectively.

Wellmont also provides services to the community at large for which it receives little or no payment. Health evaluations, screening programs, and specific services for the elderly and homebound are other services supplied. Wellmont also provides public health education, trains new health professionals and conducts health research.

(6) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately $4,478 and $6,773 for the years ended June 30, 2011 and 2010, respectively, and is included in other operating revenue in the consolidated financial statements. During FY2011, Wellmont Health Services, Inc. 20% membership interest in Spectrum Tennessee Network, LLC was exchanged through a capital contribution for a 1.19% membership interest in Lab Group Holdings, LLC. Wellmont received distributions of $5,320 and $6,730 during 2011 and 2010, respectively, which reduced Wellmont's overall investment in the affiliates.

The following table summarizes the unaudited aggregate financial information of Wellmont's investments in affiliates:

		2011	2010
Total assets	$	127,545	129,720
Total liabilities		31,326	13,943
Total net assets	$	96,219	115,777
Net revenues	$	184,648	166,815
Expenses		171,070	142,534
Revenues in excess of expenses	$	13,578	24,281

(Continued)

(Dollars in thousands)

Wellmont's equity investment in these affiliates and its ownership percentage as of June 30, 2011 and 2010 are as follows:

	Amount		Percentage	
	2011	2010	2011	2010
Takoma Regional Hospital	$ 11,161	12,645	60%	60%
Holston Valley Imaging Center (HVIC)	8,689	8,048	75	75
Advanced Home Care (AHC)	6,092	6,092	6	6
Spectrum Tennessee Network	—	3,850	—	20
Lab Group Holdings LLC	3,500	—	1	—
Others	1,735	1,384	4% – 50%	4% – 50%
	$ 31,177	32,019		

Wellmont provided billing, management, and professional services to the affiliates. Income recognized by Wellmont for the services was $943 in 2011 and $1,766 in 2010 and is included in other revenues.

Included in other receivables are $0 and $124 as of June 30, 2011 and 2010, respectively, of amounts due to Wellmont from these entities.

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

(Dollars in thousands)

(7) Investments

Long-term investments, including assets limited as to use, at June 30 are reported at fair value and consist of the following:

		2011	2010
Assets limited as to use by Board for capital improvements:			
Stock mutual funds	$	88,073	109,629
Bond mutual funds		112,176	71,698
Cash and money market funds		904	1,474
Real estate funds		8,475	7,468
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds)			
Liquid		37,421	33,915
Illiquid		26,837	23,490
		273,886	247,674
Assets limited as to use under self-insurance agreements:			
Corporate bonds		7,877	6,867
Cash and money market funds		652	558
		8,529	7,425
Assets limited as to use under bond indenture agreements:			
Cash and money market funds		37,659	47,286
U.S. Treasury bonds		1,215	1,237
Less assets limited as to use that are required for current liabilities		1,902	1,815
Assets limited as to use, net of current portion	$	319,387	301,807
Long-term investments:			
Stock mutual funds	$	12,198	9,279
Bond mutual funds		9,433	7,599
Preferred equity investment and related options		11,512	11,512
Cash, money market funds, and certificates of deposit		191	287
Real estate funds		832	1,722
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds)		2,271	1,992
Total long-term investments	$	36,437	32,391

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately $8,805 as of June 30, 2011 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which $353 was paid subsequent to June 30, 2011.

(Continued)

(Dollars in thousands)

Wellmont has invested $10,000 in the preferred equity of a regional managed services organization and $1,512 on a right of first refusal related to any future sale of this organization. This equity has a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

Wellmont's investments are concentrated in stock and bond mutual funds. In the event of a downward trend in the stock and bond markets, Wellmont's overall market value of net assets could be adversely affected by a material amount. Investments in alternative investments are generally illiquid investments whose value is determined by the general partner such as hedge funds, private equity, commingled funds and real estate funds. Distributions are only at the discretion of a voting majority of the general partners.

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, the Company recognized other-than-temporary impairment losses of $610 and $8,233 on investments as of June 30, 2011 and 2010, respectively. The unrealized losses on these mutual funds were primarily caused by the overall decline in the world's economy. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2011 and 2010, were as follows:

	Less than 12 months		12 months or more		Total	
	Unrealized Losses	Fair value	Unrealized Losses	Fair value	Unrealized Losses	Fair value
2011:						
Alternative investments	$ —	—	402	5,421	402	5,421
Stock mutual funds	616	75,091	9	158	625	75,249
	$ 616	75,091	411	5,579	1,027	80,670

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2010:						
Alternative investments	$ —	—	910	4,219	910	4,219
Stock mutual funds	2,184	29,658	24,817	83,713	27,001	113,371
	$ 2,184	29,658	25,727	87,932	27,911	117,590

(Dollars in thousands)

Investment income is comprised of the following for the years ended June 30:

		2011	2010
Interest and dividends net of amounts capitalized	$	9,407	5,330
Realized gains (losses) on investments		976	(4,318)
Investment income, net	$	10,383	1,012
Change in net unrealized gains on investments	$	42,186	22,312

(8) Land, Buildings, and Equipment

Land, buildings, and equipment at June 30 consist of the following:

		2011	2010
Land	$	49,060	41,210
Buildings and improvements		509,382	488,285
Equipment		328,604	327,896
Buildings and equipment under capital lease obligations		39,661	39,591
		926,707	896,982
Less accumulated depreciation		(484,187)	(459,935)
		442,520	437,047
Construction in progress		12,417	13,158
Land, buildings, and equipment	$	454,937	450,205

Depreciation expense for the years ended June 30, 2011 and 2010 was $46,070 and $43,755, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was $15,336 and $13,266 as of June 30, 2011 and 2010, respectively.

(Continued)

(Dollars in thousands)

(9) Other Long-Term Liabilities

Other long-term liabilities at June 30 consist of the following:

	2011	2010
Workers' compensation liability	$ 7,812	6,606
Professional and general liability	12,830	11,183
Postretirement benefit obligation	7,763	5,861
Asset retirement obligation	2,912	3,710
Deferred gain on sale of assets	628	1,382
Derivative liability	11,588	12,943
Pension benefit liability	6,526	10,018
Other	474	524
	50,533	52,227
Less current portion	(8,527)	(7,251)
Total other long-term liabilities	$ 42,006	44,976

(10) Short-Term Note Payable

At June 30, 2010, WHS had a $14,000 note payable with a variable interest rate based upon LIBOR plus 2% and a termination date of December, 2010. During 2011, the $14,000 note payable was paid in full.

(Continued)

(Dollars in thousands)

(11) Debt

(a) Long-Term Debt

Long-term debt consists of the following at June 30:

	2011	2010
Hospital Revenue Refunding Bonds, Series 2011	$ 76,165	—
Hospital Revenue Bonds, Series 2010 (Bank Qualified)	14,968	—
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2006A and 2006B	—	93,405
Hospital Revenue Refunding Bonds, Series 2005	59,580	61,810
Hospital Revenue Bonds, Series 2003	33,035	36,666
Notes payable	4,749	6,429
Capital lease obligations	16,889	19,698
Other	1,237	358
	461,623	473,366
Unamortized premium	7,287	7,538
Unamortized discount	(377)	(1,113)
	468,533	479,791
Less current maturities	(9,273)	(11,958)
	$ 459,260	467,833

(b) Series 2011 Bonds

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

The Series 2011 Bonds were issued with two maturities of $42,385 and $33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates starting on September 1, 2013 and ending on September 1, 2026 in annual amounts ranging from $865 to $4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates starting on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from $4,980 to $6,300. The Series 2011 Bonds were issued as fixed rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(c) Series 2010 Bank Qualified Bonds

On November 1, 2010, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the Board) issued $30,000 Hospital Revenue Bonds, Series 2010 (Bank Qualified). The Series 2010 Bonds were issued and sold pursuant to the Bond Purchase Agreement dated as of November 1, 2010, between the Board and First Tennessee Bank National Association. As of June 30, 2011, Wellmont has received advances on the bonds in the amount of $14,968.

Commencing on January 1, 2011, and continuing on the first day of each fiscal quarter thereafter, WHS shall pay accrued interest on the outstanding balance of the loan. Commencing on October 1, 2011 and continuing on the first day of each fiscal quarter thereafter, WHS shall also make principal payments equal to $500,000. The outstanding bonds accrue interest at a rate equal to the product of 65% of the sum of LIBOR plus the applicable margin which at June 30, 2011 was set at 1.95%.

(d) Series 2007 Bonds

On July 24, 2007, The Virginia Small Business Financing Authority issued, on behalf of Wellmont, $55,000 of Hospital Revenue Bonds, Series 2007A. The Series 2007A Bonds, with other methods of financing, were used to purchase the assets of Mountain View Regional Medical Center and Lee Regional Medical Center.

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $360 to $2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of $29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.25%.

(e) Series 2006 C

On October 26, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, $200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to: finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation and equipping of an operating room and related facilities at HCMH.

Principal on outstanding Series 2006C Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,605 to $25,330 commencing on September 1, 2017 through September 1, 2036. The outstanding bonds accrue interest at rates ranging from 5.00% to 5.25%.

(f) Series 2006 A and B

On June 23, 2006, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $98,475 of Hospital Revenue Refunding Bonds, Series 2006. This bond issuance consisted of Series A tax-exempt and Series B taxable bonds of $76,595 and $21,880, respectively. The Series 2006 Bonds together with other available funds were used to advance refund all the previously issued Hospital Revenue Bonds, Series 1993, to reimburse Wellmont for payments made on other taxable borrowings and to pay certain expenses incurred in connection with the issuance of the Series 2006 Bonds. Upon this refunding, a trust was established to pay all future bond payments related to the Series 1993 Bonds. Wellmont was deemed to have paid the Series 1993 Bonds and these Bonds are no longer deemed to be outstanding for purposes of the Series 1993 Trust Indenture.

Principal on outstanding Series 2006A Bonds was payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $875 to $6,400 commencing on September 1, 2013 through September 1, 2032; and the outstanding bonds accrued interest on a variable rate, which was reset monthly based upon the AAA-insured Municipal Market Data Index, plus 85 basis points. Principal on outstanding Series 2006B Bonds was payable through maturity in annual amounts ranging from $1,600 to $2,930 commencing on September 1, 2007 through September 1, 2016, and the outstanding bonds accrued interest at a fixed rate of 6.95%.

Outstanding Series 2006A Bonds were subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%-102% of the principal amount of the Series 2006A Bonds being redeemed, plus accrued interest thereon to the redemption date.

On October 1, 2010, the Series 2006B Bonds were called and paid in full at par value of $14,880.

On May 5, 2011, the Series 2006A Bonds were refunded with the proceeds of the Revenue Bonds, Series 2011.

(g) Series 2005

On December 8, 2005, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

Principal on outstanding Series 2005 Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,945 to $3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a "best efforts" basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate equal to the greater of (i) the Prime Rate plus 1.5% per annum, (ii) LIBOR plus 2.5% per annum, or (iii) 7.50% per annum. Wellmont shall repay the liquidity drawing amount in twelve equal quarterly installments, with the first such installment due on the first anniversary of the related liquidity drawing.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%-102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(h) Series 2003

On June 1, 2003, The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont's Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of $27,460 in fixed-rate serial bonds and $19,280 in fixed-rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from $3,230 on September 1, 2007 to $4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

(i) Master Trust Indenture

The master trust indentures and loan agreements for the 2011, 2010, 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

(Dollars in thousands)

Funds held by the trustee related to the various revenue bonds are available for specific purposes. The bond interest and revenue funds may be used only to pay interest and principal on the bonds; the debt service reserve fund may be used to pay interest and principal if sufficient funds are not available in the bond interest and revenue funds. The original issue discount and premium on all Bond Series outstanding are being amortized over the life of the bond issue using the effective-interest method.

(j) Notes Payable

During 2007, Wellmont entered into a five-year $3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011. At June 30, 2011 and 2010, $1,784 and $2,062, respectively, was outstanding on this note.

During 2008, Wellmont entered into a five-year $2,400 term note payable, which has a fixed interest rate of 7.25% and a termination date of August 2012. At June 30, 2011 and 2010, $1,120 and $1,600, respectively, was outstanding on this note.

During 2010, Wellmont entered into a $2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable has a fixed interest rate of 5.5% and a termination date of May, 2013. At June 30, 2011 and 2010, $1,845 and $2,767, respectively, was outstanding on this note.

(k) Capital Lease Obligations

Wellmont has entered into leases for certain equipment under agreements classified as capital leases that expire over periods through 2011. Assets under capital leases are included in property and equipment and have a net carrying value of $24,325 and $26,325 as of June 30, 2011 and 2010, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 4.3% to 12%.

(l) Long-term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2011 are as follows:

2012	$	9,273
2013		13,454
2014		9,572
2015		9,608
2016		9,896
Thereafter		409,820
	$	461,623

(Continued)

(Dollars in thousands)

The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2012	$ 9,273
2013	25,337
2014	26,110
2015	26,032
2016	11,887
Thereafter	362,984
	$ 461,623

Interest paid for the years ended June 30, 2011 and 2010 was $20,750 and $20,792, respectively, net of amounts capitalized. Interest costs of $590 and $2,776, net of interest income of $49 and $683 in 2011 and 2010, respectively, were capitalized.

(12) Derivative Transactions

Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to post collateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2011, and 2010, Wellmont was not required to post collateral related to its swaps.

Market risk is the adverse effect on the value of a derivative instrument that results from a change in interest rates. The market risk associated with interest-rate contracts is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

In September and October, 2008, the counterparty and credit support provider, for four of the swaps held at June 30, 2010, filed bankruptcy. Subsequent to the bankruptcy filings and into 2011, no payments were made by Wellmont or the counterparty to each other. During 2011, Wellmont and the counterparty agreed to settle all amounts due on the swaps for net cash flow receivables or payables. The bankruptcy process is underway and the ultimate outcome regarding any final settlement cannot be determined at this time.

Wellmont has a Total Return Swap on the Series 2011 Bonds with a new counterparty.

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2011 and

(Dollars in thousands)

2010 of approximately $(11,588) and $(12,943), respectively, is included in other liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately $1,355 and $(2,693), respectively, in 2011 and 2010 and is included in nonoperating gains (losses), net in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The following is a summary of the interest rate swap information as of June 30, 2011:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2011	$ 76,165	May 5, 2011	September 1, 2032	1.440%	6.200%	$ (377)
Pay fixed interest rate swap	Series 2005	59,580	December 13, 2005	September 1, 2016	3.548	0.309	(5,954)
Basis swap	Series 2002	62,730	September 1, 2002	September 1, 2032	0.090	0.124	(1,715)
Pay fixed interest rate swap	*	35,342	October 24, 2003	September 1, 2021	3.613	0.124	(3,542)
							$ (11,588)

* Previously designated bond series has been refinanced.

The following is a schedule detailing the swap information as of June 30, 2010:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2006A	$ 76,595	June 29, 2006	September 1, 2011	1.103%	5.440%	$ 1,101
Pay fixed interest rate swap	Series 2005	65,975	December 13, 2005	September 1, 2016	3.548	0.217	(6,810)
Basis swap	Series 2002	67,965	September 1, 2002	September 1, 2032	0.253	0.198	(2,710)
Pay fixed interest rate swap	Series 2006A	35,342	October 24, 2003	September 1, 2021	3.613	0.162	(4,524)
							$ (12,943)

(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was $10,344 and $9,990 for the years ended June 30, 2011 and 2010, respectively.

HVMC sponsored a noncontributory, defined benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined benefit pension plan covering substantially all its employees.

(Dollars in thousands)

HVMC's defined pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined pension plan exists. Collectively, the two defined benefit plans are referred to as the "Plans." Effective June 30, 2010, the plan was frozen for all Lonesome Pine Hospital employees and no further benefits will be accrued.

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined benefit pension plans as an asset or liability in its consolidated balance sheet and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined benefit pension plans use a June 30 measurement date.

The following table sets forth the funded status of the combined Plans, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		2011	2010
Change in benefit obligation:			
Benefit obligation at beginning of year	$	44,565	40,035
Service cost		220	230
Interest cost		2,390	2,432
Actuarial losses		896	4,008
Benefits paid		(2,239)	(2,140)
Curtailments *		(495)	—
Benefit obligation at end of year		45,337	44,565
Change in plan assets:			
Fair value of plan assets at beginning of year		34,547	33,326
Actual return on plan assets		6,503	3,361
Benefits paid		(2,239)	(2,140)
Fair value of plan assets at end of year		38,811	34,547
Funded status	$	(6,526)	(10,018)
Amounts recognized in the accompanying consolidated balance sheets:			
Pension benefit liability (other long-term liabilities)	$	(6,526)	(10,018)

* Reflects frozen benefit accruals for Lonesome Pine participants as of June 30, 2011.

(Continued)

(Dollars in thousands)

		2011	2010
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:			
Unrecognized actuarial loss	$	8,565	13,158
Unrecognized prior service cost		—	2
Net amounts included as an accumulated charge to unrestricted net assets	$	8,565	13,160
Calculation of change in unrestricted net assets:			
Accumulated charge to unrestricted net assets, end of year	$	8,565	13,160
Reversal of accumulated charge to unrestricted net assets, prior year		(13,160)	(10,853)
Change in unrestricted net assets	$	(4,595)	2,307
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Prior service credit adjustment for curtailment	$	(1)	—
Actuarial (gain) loss arising during the year		(3,763)	2,907
Amortization of actuarial loss		(831)	(600)
Amortization of prior service cost		—	—
Net amounts recognized as a charge to unrestricted net assets	$	(4,595)	2,307

(Continued)

(Dollars in thousands)

		2011	2010
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2012:			
Amortization of net loss	$	382	791
Amortization of prior service cost		—	—
Estimated future benefit payments:			
Fiscal 2012		2,276	2,220
Fiscal 2013		2,369	2,337
Fiscal 2014		2,492	2,472
Fiscal 2015		2,596	2,578
Fiscal 2016 (FY10 fiscal 2016 – 2020)		2,671	14,278
Fiscal 2017 – 2021		14,819	
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		5.50%	5.50%
Weighted average rate of increase in future compensation levels		3.00	3.00
Components of net periodic benefit cost (benefit):			
Service cost	$	220	230
Interest cost		2,390	2,432
Expected return on plan assets		(2,340)	(2,259)
Amortization of net loss		831	600
Amortization of unrecognized prior service cost curtailments		1	—
Net periodic benefit cost	$	1,102	1,003
Weighted average assumptions used to determine net periodic benefit cost:			
Settlement (discount) rate		5.50%	6.25%
Expected long-term return on plan assets (HVMC)		7.00	7.00
Expected long-term return on plan assets (LPH)		7.00	7.00
Weighted average rate of increase in future compensation levels		3.00	3.00

Wellmont's overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont has developed a Plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

(Continued)

(Dollars in thousands)

The table below shows the target allocation and actual asset allocations as of June 30, 2011 and 2010:

Asset	Target allocation	2011	2010
Equity securities	65%	46%	56%
Fixed income	28	35	27
Cash	5 – 15%	2	1
Other	5 – 15%	17	16

Wellmont monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

HVMC also participates in a health and welfare plan for its retirees. The plan provides postretirement medical and life insurance benefits to certain employees who meet minimum age and service requirements. Effective January 1, 1995, the death benefit was changed to provide a flat $5 benefit to all future retirees. During 1995, the medical program for retirees was amended to terminate medical benefits for any active employees who would not meet the full eligibility requirements of the program by January 1, 1996. The plan is contributory and contains other cost-sharing features such as deductibles and coinsurance.

(Continued)

(Dollars in thousands)

The following table sets forth the postretirement plan's funded status, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		Postretirement benefits	
		2011	**2010**
Change in benefit obligation:			
Benefit obligation at beginning of year	$	5,861	5,653
Interest cost		365	320
Plan participants contributions		79	73
Actuarial losses		1,686	197
Benefits Paid		(228)	(382)
Benefit obligation at end of year		7,763	5,861
Change in plan assets:			
Fair value of plan assets at beginning of year		—	—
Employer contribution		149	309
Plan participants contributions		79	73
Benefits paid		(228)	(382)
Fair value of plan assets at end of year		—	—
Funded Status	$	7,763	5,861
Amounts recognized in the consolidated balance sheets consist of:			
Noncurrent assets	$	—	—
Current liabilities		(271)	(499)
Noncurrent liabilities		(7,492)	(5,362)
Accumulated charge to unrestricted net assets		1,755	3,560
	$	(6,008)	(2,301)

Amounts recognized as an accumulated credit to unrestricted net assets consist of:

		2011	**2010**
Net actuarial gain	$	1,755	3,560

(Continued)

(Dollars in thousands)

Net periodic benefic cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2011 and 2010 were:

	Postretirement benefits	
	2011	2010
Net periodic benefit cost		
Interest cost	$ 365	320
Amortization of net gain	(119)	(319)
Net periodic benefit cost recognized	246	1
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	1,686	197
Amortization of net gain	119	319
Total recognized as a charge to unrestricted net assets	1,805	516
Total recognized in net periodic benefit cost and unrestricted net assets	$ 2,051	517

The net gain and prior service credit for the defined benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $(88) and $(261), respectively. Weighted average assumptions used to determine benefit obligations for 2011 and 2010 were as follows:

	2011	2010
Discount rate	5.00%	5.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2011 and 2010 were as follows:

	Postretirement benefits	
	2011	2010
Discount rate	5.00%	6.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

(Continued)

(Dollars in thousands)

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 5% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2011.

The following table summarizes the effect of one-percentage-point increase/decrease in healthcare costs trends:

		2011	2010
Effect of one-percentage point increase in healthcare cost trend on:			
Service and interest cost	$	27	20
Accumulated pension benefit obligation		545	330
Effect of one-percentage point decrease in healthcare cost trend on:			
Service and interest cost		(24)	(18)
Accumulated pension benefit obligation		(486)	(294)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2011 and 2010, respectively, were as follows:

		Fair Value measurement at June 30, 2011 Pension benefits – plan assets			
		Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:					
Stock mutual funds	$	31,311	31,311	—	—
Cash and money market funds		764	764	—	—
Alternative funds		6,868	—	3,280	3,588
Total	$	38,943	32,075	3,280	3,588

(Continued)

(Dollars in thousands)

	Fair Value measurement at June 30, 2010 Pension benefits - plan assets			
	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Stock mutual funds	$ 28,803	19,412	9,391	—
Cash and money market funds	244	244	—	—
Alternative funds	5,500	—	—	5,500
Total	$ 34,547	19,656	9,391	5,500

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (level 3) as defined in ASC 820 for the years ended June 30, 2011 and 2010:

	Alternative investments
Balance at June 30, 2009	$ 5,133
Net change in value	254
Purchases, issuances, and settlements	113
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2010	5,500
Net change in value	1,349
Purchases, issuances, and settlements	19
Transfers in and/or out of Level 3 (net)	(3,280)
Balance at June 30, 2011	$ 3,588

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers' compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont has established revocable self-insurance trust funds to provide for professional and general liability claims and workers' compensation claims and related expenses. Wellmont's contributions to the self-insurance trusts are based upon actuarial determinations by an independent service company. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on

(Dollars in thousands)

actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Insurance expense under these programs amounted to approximately $4,692 and $3,414 for the years ended June 30, 2011 and 2010, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2011 and 2010, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents which occurred through June 30, 2011 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2011 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

Wellmont is also self-insured for medical and other healthcare benefits provided to its employees and their families. A provision for estimated incurred but not reported claims has been provided in the consolidated financial statements.

(15) Commitments and Contingencies

Construction in progress at June 30, 2011 and 2010 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately $12,448 at June 30, 2011. Wellmont has entered into contracts of $12,448 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was $18,179 and $16,857 for the years ended June 30, 2011 and 2010, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2011 are as follows:

2012	$	13,168
2013		10,071
2014		6,269
2015		5,491
2016		4,190
Thereafter		28,904
	$	68,093

Wellmont has entered into contractual employment relationships with physicians to provide services to Wellmont physician practices that are intended to qualify under the employee safe harbor of the Anti-Kickback Statute and the employee exception of the Physician Self-Referral Law. These contracts

(Dollars in thousands)

have terms of varying lengths, guarantee certain base payments, and may provide for additional incentives based upon productivity.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, such matters as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes Wellmont is in compliance with fraud and abuse statutes and other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

(16) Functional Expense Disclosure

Wellmont provides healthcare services to residents within its geographic location. Expenses based upon functional classification related to providing these services during the years ended June 30 are as follows:

		2011	2010
Professional care of patients	$	636,403	583,222
Administrative and general		142,768	117,123
Fund-raising		913	1,235
	$	780,084	701,580

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate company state income tax returns. These companies have combined net operating loss carry forwards for federal income tax purposes of approximately $67,000 at June 30, 2011, which begin expiring in fiscal 2018 and expire through 2032. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont Health System participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont Health System files a Form 990-T with the IRS to report such activity. Wellmont Health System has net operating loss carry forwards for federal income tax purposes of approximately $1,766 for unrelated business activities. Management believes that it is not more likely than not that deferred tax assets arising from net operating loss carry forwards will be realizable. Accordingly, these are fully reserved at June 30, 2011 and 2010.

(Dollars in thousands)

(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2011 and 2010, was as follows:

	2011	2010
Medicare	42%	46%
TennCare	4	4
Medicaid	9	8
Other third-party payors	35	31
Patients	10	11
	100%	100%

(19) Disclosures about Fair Value of Financial Instruments

(a) Fair Value of Financial Instruments

The following methods and assumptions were used to estimate fair value of each class of instruments:

- *Cash and Cash Equivalents*

  The carrying amount approximates fair value due to the short maturities of these instruments.

- *Patient Accounts and Other Receivables*

  The net recorded carrying value approximates fair value due to the short maturities of these instruments.

- *Investments and Assets Limited as to Use*

  The fair values of investments and assets limited as to use are based on quoted market prices and quotes obtained from security brokers or, in the case of the limited partnerships, by the general partner.

- *Accounts Payable and Accrued Expenses*

  The carrying amount approximates fair value due to the short maturities of these liabilities.

- *Estimated Third-Party Payor Settlements, Other Long-Term Liabilities*

  The carrying amount approximates fair market value due to the nature of these liabilities.

- *Long-Term Debt*

  The fair value of revenue bonds, using current market rates, was estimated at $419,960 and $422,290 for the years ended June 30, 2011 and 2010, respectively.

(b) Fair Value Hierarchy

On July 1, 2008, Wellmont adopted new guidance issued by FASB for fair value measurement of financial assets and financial liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis now codified into ASC 820, *Fair Value Measurements and Disclosures*. ASC 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

In conjunction with the adoption of the new guidance, Wellmont elected to early adopt the measurement provisions of Accounting Standards Update No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was $66,529 and $59,397 at June 30, 2011 and 2010, respectively.

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2011:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 36,558	—	—	36,558
Assets limited as to use:				
Stock mutual funds	88,073	—	—	88,073
Bond mutual funds	112,176	—	—	112,176
Cash and money market funds	39,215	—	—	39,215
Real estate funds	8,475	—	—	8,475
Alternative investments	—	26,480	37,778	64,258
Corporate bonds	7,877	—	—	7,877
U.S. Treasury bonds	1,215	—	—	1,215
Subtotal	293,589	26,480	37,778	357,847
Long-term investments:				
Stock mutual funds	12,198	—	—	12,198
Bond mutual funds	9,433	—	—	9,433
Cash and money market funds	191	—	—	191
Real estate funds	832	—	—	832
Alternative investments	—	2,271	—	2,271
Subtotal	22,654	2,271	—	24,925
	$ 316,243	28,751	37,778	382,772
Liabilities:				
Derivatives liability	$ —	11,588	—	11,588
Total	$ —	11,588	—	11,588

(Continued)

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2010:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 35,711	—	—	35,711
Assets limited as to use:				
Stock mutual funds	109,629	—	—	109,629
Bond mutual funds	71,698	—	—	71,698
Cash and money market funds	49,318	—	—	49,318
Real estate funds	7,468	—	—	7,468
Alternative investments	—	18,043	39,362	57,405
Corporate bonds	6,867	—	—	6,867
U.S. Treasury bonds	1,237	—	—	1,237
Subtotal	281,928	18,043	39,362	339,333
Long-term investments:				
Stock mutual funds	9,279	—	—	9,279
Bond mutual funds	7,599	—	—	7,599
Cash and money market funds	287	—	—	287
Real estate funds	1,722	—	—	1,722
Alternative investments	—	1,992	—	1,992
Subtotal	18,887	1,992	—	20,879
	$ 300,815	20,035	39,362	360,212
Liabilities:				
Derivatives liability	$ —	12,943	—	12,943
Total	$ —	12,943	—	12,943

(Continued)

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2011 and 2010:

		Alternative investments
Balance at June 30, 2009:	$	33,291
Total realized and unrealized gains (losses)		
Included in revenues and gains in excess of expenses and losses		—
Included in changes in net assets		469
Purchases, issuances and settlements		5,602
Transfers in and/or out of Level 3 (net)		—
Balance at June 30, 2010		39,362
Total realized and unrealized gains (losses)		
Included in revenues and gains in excess of expenses and losses		
Included in changes in net assets		(3,401)
Purchases, issuances and settlements		1,817
Transfers in and/or out of Level 3 (net)		—
Balance at June 30, 2011	$	37,778

(20) Subsequent Events

WHS has evaluated subsequent events from the balance sheet date through October 27, 2011, the date at which the financial statements were available to be issued. No material subsequent events were identified for recognition.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2012 and 2011

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

Table of Contents

KPMG LLP
Suite 1000
401 Commerce Street
Nashville, TN 37219-2422

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

We have audited the accompanying consolidated balance sheets of Wellmont Health System and affiliates (Wellmont) as of June 30, 2012 and 2011, 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 Wellmont'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 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 Wellmont's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that 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 consolidated financial position of Wellmont Health System and affiliates as of June 30, 2012 and 2011, and the consolidated results of their operations and changes in their net assets, and their cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

As discussed in note 2 to the consolidated financial statements, Wellmont changed its presentation of provision for bad debts as a result of the adoption of Accounting Standards Update No. 2011-07, *Health Care Entities: Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*.

KPMG LLP

October 24, 2012

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2012 and 2011

(Dollars in thousands)

Assets	2012	2011
Current assets:		
Cash and cash equivalents	$ 44,930	36,558
Assets limited as to use, required for current liabilities	4,372	1,902
Patient accounts receivable, less allowance for uncollectible accounts of approximately $25,656 and $24,246 in 2012 and 2011, respectively	108,265	101,565
Other receivables	23,805	9,904
Inventories	17,862	17,830
Prepaid expenses and other current assets	7,462	7,163
Total current assets	206,696	174,922
Assets limited as to use, net of current portion	339,030	319,387
Land, buildings, and equipment, net	458,048	454,937
Other assets:		
Long-term investments	36,633	36,437
Investments in affiliates	32,646	31,177
Deferred debt expense, net	5,419	5,847
Goodwill	17,090	16,721
Other	651	1,875
	92,439	92,057
Total assets	$ 1,096,213	1,041,303
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	$ 11,913	9,273
Accounts payable and accrued expenses	81,243	70,943
Estimated third-party payor settlements	15,535	9,533
Current portion of other long-term liabilities	5,782	8,527
Total current liabilities	114,473	98,276
Long-term debt, less current portion	459,654	458,882
Other long-term liabilities, less current portion	54,060	42,384
Total liabilities	628,187	599,542
Net assets:		
Unrestricted	458,218	434,661
Temporarily restricted	5,739	3,570
Permanently restricted	1,304	1,174
Total net assets attributable to Wellmont	465,261	439,405
Noncontrolling interests	2,765	2,356
Total net assets	468,026	441,761
Commitments and contingencies		
Total liabilities and net assets	$ 1,096,213	1,041,303

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2012 and 2011

(Dollars in thousands)

	2012	2011
Revenue:		
Patient service revenue	$ 813,229	767,450
Provision for bad debt	(71,407)	(37,858)
Net patient revenue less provision for bad debt	741,822	729,592
Other revenues	47,904	29,799
Total revenue	789,726	759,391
Expenses:		
Salaries and benefits	368,772	347,185
Medical supplies and drugs	164,397	160,565
Purchased services	79,509	80,348
Interest	21,677	20,750
Depreciation and amortization	46,403	46,059
Other	86,645	87,319
Total expenses	767,403	742,226
Income from operations	22,323	17,165
Nonoperating gains (losses):		
Investment income	17,272	10,383
Derivative valuation adjustments	1,807	1,355
Other, net	—	(519)
Gain on refinancing	—	1,042
Nonoperating gains, net	19,079	12,261
Revenue and gains in excess of expenses and losses before discontinued operations	41,402	29,426
Discontinued operations	88	44
Revenue and gains in excess of expenses and losses	41,490	29,470
Income attributable to noncontrolling interests	(1,670)	(1,238)
Revenues and gains in excess of expenses and losses attributable to Wellmont	39,820	28,232
Other changes in unrestricted net assets:		
Change in net unrealized gains on investments	(9,534)	42,186
Net assets released from restrictions for additions to land, buildings, and equipment	3,766	2,852
Change in the funded status of benefit plans and other	(10,495)	2,771
Increase in unrestricted net assets	23,557	76,041
Changes in temporarily restricted net assets:		
Contributions	6,661	2,566
Net assets released from temporary restrictions	(4,492)	(3,547)
Increase (decrease) in temporarily restricted net assets	2,169	(981)
Changes in permanently restricted net assets – investment income	130	6
Changes in noncontrolling interests:		
Income attributable to noncontrolling interests	1,670	1,238
Distributions to noncontrolling interests	(1,261)	(1,178)
Change in noncontrolling percentages	—	(92)
Increase (decrease) in noncontrolling interests	409	(32)
Change in net assets	26,265	75,034
Net assets, beginning of year	441,761	366,727
Net assets, end of year	$ 468,026	441,761

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2012 and 2011

(Dollars in thousands)

	2012	2011
Cash flows from operating activities:		
Change in net assets	$ 26,265	75,034
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	46,403	46,070
Gain on disposal of land, buildings, and equipment	(458)	(864)
Equity in earnings of affiliated organizations	(7,233)	(4,478)
Distributions from affiliated organizations	5,764	5,320
Amortization of deferred financing costs	428	158
Net realized and unrealized loss (gain) on investments	2,633	(43,162)
Provision for bad debts	71,407	37,893
Change in fair value of derivative instruments	(1,807)	(1,355)
Gain on refinancing	—	(1,042)
Changes in assets and liabilities:		
Patient accounts receivable	(78,107)	(45,402)
Other current assets	(331)	303
Other assets	(13,920)	(538)
Accounts payable and accrued expenses	10,230	(6,729)
Estimated third-party payor settlements	6,002	(2,139)
Other current liabilities	(2,745)	1,276
Other liabilities	13,672	(63)
Net cash provided by operating activities	78,203	60,282
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	149,087	186,085
Purchase of investments	(174,029)	(164,635)
Purchase of land, buildings, and equipment	(46,026)	(42,352)
Proceeds from the sale of buildings and equipment	1,721	244
Cash paid for acquisitions	(813)	(7,826)
Net cash used in investing activities	(70,060)	(28,484)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	11,368	91,133
Payments on long-term debt	(11,139)	(106,069)
Payment of debt issuance costs	—	(2,015)
Payments on line of credit	—	(14,000)
Net cash provided by (used in) financing activities	229	(30,951)
Net increase in cash and cash equivalents	8,372	847
Cash and cash equivalents, beginning of year	36,558	35,711
Cash and cash equivalents, end of year	$ 44,930	36,558

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of $3,281 and $5,785 in 2012 and 2011, respectively.

Additions to property and equipment financed through current liabilities of $2,487 and $2,933 in 2012 and 2011, respectively.

See accompanying notes to consolidated financial statements.

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont) was formed to assume operations of Bristol Regional Medical Center (BRMC) and Holston Valley Health Care, Inc. (HVHC), including Holston Valley Medical Center, Inc. (HVMC), and to act as sole corporate member of its consolidated foundation. Effective July 1, 1996, under terms of an agreement and plan of consolidation and merger, BRMC and HVHC, including HVMC, were merged and consolidated into Wellmont. Effective January 1, 1997, Lonesome Pine Hospital (LPH), a Virginia corporation, was merged into Wellmont under terms of a plan of merger and merger agreement. Effective July 1, 2000, Hawkins County Memorial Hospital (HCMH) transferred its operations and operating assets to Wellmont Hawkins County Memorial Hospital (WHCMH), a tax-exempt organization that is wholly owned and controlled by Wellmont. Hancock County Hospital (HCH), a critical access hospital, was opened in March 2005 to help provide for the immediate healthcare needs of the residents of Sneedville and the surrounding counties. As of July 16, 2007, Wellmont acquired Jenkins Community Hospital in Kentucky. As of August 1, 2007, Wellmont acquired two hospitals in Virginia, Lee Regional Medical Center in Pennington Gap and Mountain View Regional Medical Center in Norton. On May 30, 2008, Wellmont acquired the Holston Valley Cath Lab, an outpatient lab. On May 1, 2010, Wellmont acquired Cardiovascular Associates. On January 1, 2011, Wellmont acquired Pulmonary Associates of Kingsport.

As of April 30, 2009, Wellmont closed Jenkins. The consolidated financial statements for the years ended June 30, 2012 and 2011 present Jenkins as a discontinued operation. Losses of $4 and $120 for the years ended June 30, 2012 and June 30, 2011, respectively, are included in discontinued operations.

As of September 23, 2010 Wellmont sold the majority of Medical Mall Pharmacy's assets to a national pharmacy company for $1,300 plus inventory value and recorded a gain of approximately $517 at June 30, 2011. The consolidated financial statements for the years ended June 30, 2012 and 2011 present Medical Mall Pharmacy as a discontinued operation. The gains (losses) of $92 and $(353) for the years ended June 30, 2012 and June 30, 2011, respectively, are included in discontinued operations.

All acute care operations remain separately licensed and are treated as operating divisions within Wellmont. Wellmont's continuing operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

The consolidated financial statements include the acute care operations of the above entities along with:

- Wellmont Foundation (the Foundation), which was created from the merger of Bristol Regional Medical Center Foundation and Holston Valley Health Care Foundation, Inc. The Foundation conducts fund-raising activities for the benefit of Wellmont.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

- The Alzheimer's Center of East Tennessee was merged into Wellmont and changed its name to Wellmont Madison House effective September 1, 1997. Wellmont is the sole corporate member and the consolidated financial statements include the operations of this entity.

All significant intercompany accounts and transactions have been eliminated in the accompanying consolidated financial statements.

(2) Significant Accounting Policies

A summary of significant accounting policies is as follows:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) 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. Significant estimates include: allowances for contractual adjustments and bad debts; third-party payor settlements; valuation of investments, land, buildings, equipment and goodwill; and self-insurance and other liabilities. Actual results could differ from these estimates.

(b) Cash and Cash Equivalents

Wellmont considers all highly liquid investments with a maturity of three months or less when purchased, excluding amounts whose use is limited by board of directors' designation or other arrangements under trust agreements, to be cash equivalents.

(c) Investments

Marketable equity securities and debt securities are recorded at fair value and classified as other than trading. Fair value is determined primarily using quoted prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date. However, Wellmont also uses observable and unobservable inputs for investments without quoted market prices to determine the fair value of certain investments at the measurement date. Investments in limited partnerships are recorded at fair value as determined by the partnership using net asset value. Wellmont has adopted the measurement provisions of Accounting Standards Update (ASU) No. 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. Investments in affiliates in which Wellmont has significant influence but does not control are reported on the equity method of accounting, which represents Wellmont's equity in the underlying net book value. Long-term investments include those investments that have not been designated by the board of directors for specific purposes and are also not intended to be used for the liquidation of current liabilities. Investment income is recognized when earned.

Realized gains and losses are determined on the specific-identification method and included in investment income with interest and dividends. Investment income is reported net of related investment fees. Unrealized gains and losses are included in other changes in unrestricted net assets except for losses determined to be other than temporary, which are considered realized losses and included in investment income.

(d) Assets Limited as to Use

Assets limited as to use primarily include assets held by trustees under bond indenture and self-insurance agreements, as well as designated assets set aside by the board of directors for future capital improvements, over which the board of directors retains control and may, at its discretion, subsequently use for other purposes. Amounts required to meet current liabilities of Wellmont have been reclassified to current assets in the accompanying consolidated balance sheets.

(e) Inventories

Inventories are stated at the lower of cost or market value and are valued principally by the first-in, first-out and average-cost methods.

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, if purchased, or fair value at date of donation. Depreciation is computed using the straight-line method based on the estimated useful life of the asset, ranging from 3 to 40 years. Buildings and equipment held under capital leases are recorded at net present value of future lease payments and are amortized on a straight-line basis over the shorter of the lease term or estimated useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Upon sale or retirement of land, buildings, or equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss, if any, is included in other revenues on the consolidated statements of operations and changes in net assets. 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.

Wellmont evaluates long-lived assets for impairment on annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset.

(Dollars in thousands)

(g) Goodwill

Effective July 1, 2010, Wellmont adopted Accounting Standards Update (ASU) No. 2010-07, *Not for Profit Entities: Mergers and Acquisitions* which in part requires healthcare entities to follow Accounting Standards Codification (ASC) Topic 350-20-35, *Intangibles – Goodwill and Other*. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. The goodwill impairment test is a two-step test. Under the first step, the fair value of each reporting unit is compared with its carrying value (including goodwill). If the fair value of a reporting unit is less than its carrying value, an indication of goodwill impairment exists for the reporting unit and the entity must perform step two of the impairment test (measurement). Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. The annual impairment test is performed as of June 30. A summary of goodwill and related amortization for the years ended June 30 follows:

		2011	Additions	Decreases	2012
Goodwill	$	16,721	369	—	17,090

		2010	Additions	Decreases	2011
Goodwill	$	9,501	7,220	—	16,721

(h) Deferred Debt Expense

Deferred debt expense is amortized over the life of the related bond issues using the effective-interest method.

(i) Derivative Financial Instruments

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) Asset Retirement Obligations

Asset retirement obligations (AROs) are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value, and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, Wellmont records period-to-period changes in the ARO liability resulting from the passage of time and revisions to either the timing or the amount of the original estimate of undiscounted cash flows. Wellmont derecognizes ARO liabilities when the related obligations are settled.

(k) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by Wellmont has been limited by donors to a specific-time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by Wellmont in perpetuity. Generally, donors of permanently restricted assets permit use of all or part of the income earned on related investments for general or specific purposes.

Temporarily restricted net assets relate primarily to amounts held by the Foundation and include amounts restricted for future capital expenditures and for operations of such areas as children's healthcare services, hospice, and cancer care.

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2012 and 2011 primarily included amounts related to the purchase of equipment for pediatrics, cancer, and other healthcare operations.

Wellmont has adopted guidance issued by Financial Accounting Standards Board (FASB), which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA). Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of five individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. On the basis of historical experience, a significant portion of Wellmont's uninsured patients will be unable or unwilling to pay for the services provided. Therefore, Wellmont records a significant provision for bad debts related to uninsured patients in the period the services are provided. This provision for bad debts is presented on the statement of operations as a component of net patient revenue. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

Patient accounts receivable are reported net of both an allowance for contractual adjustments and an allowance for uncollectible accounts. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, TennCare, Medicaid, and other third-party payment programs. Wellmont's policy does not require collateral or other security for patient accounts receivable. Wellmont routinely obtains assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans, or policies.

(m) Revenue and Gains in Excess of Expenses and Losses

The consolidated statements of operations and changes in net assets include revenue and gains in excess of expenses and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include changes in net

unrealized gains (losses) on investments other than trading securities, changes in the funded status of Wellmont's defined-benefit plan, contributions of long-lived assets, including assets acquired using contributions that, by donor restriction, were to be used for the purposes of acquiring such assets, and cumulative effects of changes in accounting principles.

For purposes of financial statement display, those activities directly associated with Wellmont's mission of providing healthcare services are considered to be operating activities. Nonoperating activities primarily include investment and related activities. Other operating revenues primarily include cafeteria, rental, meaningful use incentives, and income from affiliates.

(n) Contributed Resources

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted contributions, and are excluded from revenue and gains in excess of expenses and losses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. Gifts are reported as either a temporarily or permanently restricted contribution if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions. Unrestricted contributions are included in other revenues.

(o) Federal Income Taxes

The Wellmont entities are primarily classified as organizations exempt from federal income taxes under Section 501(a) as entities described in Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been included for these entities in the consolidated financial statements. The operations of Wellmont, Inc. are subject to state and federal income taxes, which are accounted for in accordance with ASC Topic 740, *Income Taxes*; however, such amounts are not material.

On July 1, 2007, Wellmont adopted new guidance issued on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

(p) New Accounting Pronouncements

In August 2010, the Financial Accounting Standards Board issued ASU No. 2010-23, *Measuring Charity Care for Disclosure* (ASU 2010-23). ASU 2010-23 requires that cost be used as the measurement basis for charity care disclosures purposes and that cost can be identified as direct and indirect costs of providing charity care. The adoption of ASU 2010-23 as of July 1, 2011 had no impact on the consolidated financial statements. In August 2010, the Financial Accounting Standards Board issued ASU No. 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24). ASU 2010-24 clarifies that healthcare entities should not net insurance recoveries against the related claim liability and that the claim liability amount should be determined without consideration of insurance recoveries. The adoption of ASU 2010-24 as of July 1, 2011 had no impact on the consolidated financial statements.

In July 2011, the Financial Accounting Standards Board issued ASU No. 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07). Wellmont adopted ASU 2011-07 on July 1, 2011 and applied it retrospectively to fiscal year 2011. Wellmont's presentation of provision for bad debts in the consolidated statements of operations and changes in net assets is now shown as a deduction from net patient service revenue. In addition, there are enhanced disclosures about the entities policies for recognizing revenue and assessing bad debts. The ASU also requires disclosures of patient service revenue as well as qualitative and quantitative information about changes in the allowance for doubtful accounts.

The Financial Accounting Standards Board issued ASU No. 2011-08, *Intangibles – Goodwill and Other (Topic 350): Testing Goodwill for Impairment* (ASU 2011-08) in September 2011. ASU 2011-08 allows entities to assess qualitative factors first to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If the initial determination is negative, then the entity does not need to perform the two-step impairment test. If the conclusion is otherwise, then the entity must perform the first step of the two-step impairment test. The adoption of ASU 2011-08 will be effective for Wellmont beginning in fiscal year 2013.

The Financial Accounting Standards Board issued ASU No. 2011-11, *Balance Sheet (Topic 210): Disclosures about Offsetting Assets and Liabilities* (ASU 2011011) in December 2011. This ASU requires improved disclosures about financial instruments and derivative instruments that are offset in accordance with Section 210-20-45 or Section 815-10-45 or subject to an enforceable master netting arrangement or similar agreement. The adoption of ASU 2011-11 will be effective for Wellmont beginning in fiscal year 2014.

(q) Reclassifications

Certain 2011 amounts have been reclassified to conform to the 2012 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

(Dollars in thousands)

(3) 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 consolidated statements of operations and changes in net assets is as follows for the years ended June 30:

		2012	2011
Gross patient service revenue	$	2,398,999	2,260,489
Less:			
Contractual adjustments and other discounts		(1,524,110)	(1,431,215)
Charity care		(61,660)	(61,824)
Net patient service revenue before provision for bad debts		813,229	767,450
Less provision for bad debts		(71,407)	(37,858)
Net patient service revenue	$	741,822	729,592

Wellmont's allowance for doubtful accounts is predominantly for self-pay patients and patient balances remaining after third-party payments. The provision for bad debts increased $33,549 from fiscal 2011 to fiscal 2012 and the net write-offs increased $31,272 from fiscal 2011 to fiscal 2012. Both increases were the result of negative trends experienced in the collection of amounts from patients in fiscal year 2012 as a result of the economic conditions and due to the increased proportion of patient financial responsibility for those patients with health insurance. Wellmont has not changed its charity care or uninsured discount policies during fiscal 2012. Wellmont does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(4) Third-Party Reimbursement Arrangements

Wellmont renders services to patients under contractual arrangements with the Medicare and Medicaid programs. The Medicaid program in Tennessee was replaced with a managed care program known as TennCare, which was designed to cover previous Medicaid eligible enrollees. Amounts earned under these contractual arrangements are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Management believes that adequate provision has been made for any adjustments that may result from such reviews. Participation in these programs subjects Wellmont to significant rules and regulations; failure to adhere to such could result in fines, penalties, or expulsion from the programs.

Wellmont contracts with various managed care organizations under the TennCare program. TennCare reimbursement for both inpatient and outpatient services is based upon prospectively determined rates, including diagnostic-related group assignments, fee schedules, and per diem amounts. Reimbursement under the Medicaid program is also based upon prospectively determined amounts.

(Dollars in thousands)

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid-eligible and other low-income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

Net patient service revenue in 2012 and 2011 related to Medicare, TennCare, and Medicaid and net patient accounts receivable at June 30, 2012 and 2011 from Medicare, TennCare, and Medicaid were as follows:

		2012	2011
Net patient service revenue:			
Medicare	$	312,202	285,821
TennCare		28,548	23,791
Medicaid		19,541	22,336
Net patient accounts receivable:			
Medicare	$	41,883	34,671
TennCare		2,957	2,798
Medicaid		5,244	3,427

Wellmont has filed cost reports with Medicare and Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2006 and audit adjustments have been received and considered for certain hospitals and year-ends through June 30, 2010.

Wellmont has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, per diem rates, and discounts from established charges.

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately $3,575 and $2,319 in 2012 and 2011, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2012 could differ materially from actual settlements based on the results of third-party audits.

(5) Meaningful Use Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record (EHR) technology. The Medicare incentive payments are paid out to qualifying hospitals and physician groups over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals and physician groups must meet EHR "meaningful use" criteria that become more stringent over three stages as determined by Centers for Medicare & Medicaid Services (CMS). Medicaid programs and payment schedules vary from state to state.

During the fiscal year ended June 30, 2012, Wellmont recorded $13.1 million in other operating revenue related to the EHR and meaningful use incentives. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

Amounts recognized represent management's best estimates for payments ultimately expected to be received based on estimated discharges, charity care, and other input data. Subsequent changes to these estimates will be recognized in other operating revenue in the period in which additional information is available. Such estimates are subject to audit by the federal government or its designee.

(6) Charity Care and Community Services

Wellmont accepts all patients within its primary service area regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies that consider, among other factors, generally recognized poverty income levels.

Wellmont maintains records to identify and monitor the level of charity care it provides. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were $61,660, $16,144, and 2.57%, respectively, for the year ended June 30, 2012 and $61,824, $16,982, and 2.73%, respectively, for the year ended June 30, 2011.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled $44,432 and $49,180, for the years ended June 30, 2012 and 2011, respectively.

Wellmont also provides services to the community at large for which it receives little or no payment. Health evaluations, screening programs, and specific services for the elderly and homebound are other services supplied. Wellmont also provides public health education, trains new health professionals, and conducts health research.

(Dollars in thousands)

(7) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately $7,233 and $4,478 for the years ended June 30, 2012 and 2011, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont received distributions of $5,764 and $5,320 during 2012 and 2011, respectively, which reduced Wellmont's overall investment in the affiliates.

The following table summarizes the unaudited aggregate financial information of Wellmont's investments in affiliates:

		2012	2011
Total assets	$	127,206	127,545
Total liabilities		27,732	31,326
Total net assets	$	99,474	96,219
Net revenues	$	228,644	184,648
Expenses		207,806	171,070
Revenues in excess of expenses	$	20,838	13,578

Wellmont's equity investment in these affiliates and its ownership percentage as of June 30, 2012 and 2011 is as follows:

		Amount		Percentage	
		2012	2011	2012	2011
Takoma Regional Hospital	$	12,350	11,161	60%	60%
Holston Valley Imaging Center (HVIC)		8,818	8,689	75	75
Advanced Home Care (AHC)		6,092	6,092	6	6
Lab Group Holdings LLC		3,500	3,500	1	1
Others		1,886	1,735	4% – 50%	4% – 50%
	$	32,646	31,177		

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

Wellmont provided billing, management, and professional services to some of the affiliates. Income recognized by Wellmont for the services was $929 in 2012 and $943 in 2011 and is included in other revenues.

(Dollars in thousands)

During the fiscal year ended June 30, 2012, Takoma Regional Hospital recorded $3.2 million in net revenue related to the EHR and meaningful use incentives of which $1.9 million is included as income in affiliates in Wellmont's consolidated financial statements. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

Included in other receivables are $374 and $320 as of June 30, 2012 and 2011, respectively, of amounts due to Wellmont from these entities.

(8) Investments

Long-term investments, including assets limited as to use, at June 30 are reported at fair value and consist of the following:

		2012	2011
Assets limited as to use by Board for capital improvements:			
Stock mutual funds	$	88,942	80,413
Bond mutual funds		163,401	119,836
Cash and money market funds		1,492	904
Real estate funds		7,157	8,475
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):			
Liquid		9,616	37,421
Illiquid		27,373	26,837
		297,981	273,886
Assets limited as to use under self-insurance agreements:			
Corporate bonds		2,673	7,877
Cash and money market funds		32	652
		2,705	8,529
Assets limited as to use under bond indenture agreements:			
Cash and money market funds		42,716	37,659
U.S. Treasury bonds		—	1,215
Less assets limited as to use that are required for current liabilities		4,372	1,902
Assets limited as to use, net of current portion	$	339,030	319,387

(Continued)

(Dollars in thousands)

	2012	2011
Long-term investments:		
Stock mutual funds	$ 10,321	10,897
Bond mutual funds	13,926	10,734
Preferred equity investment and related option	11,512	11,512
Cash, money market funds, and certificates of deposit	189	191
Real estate funds	685	832
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds)	—	2,271
Total long-term investments	$ 36,633	36,437

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately $6,705 as of June 30, 2012 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which $157 was paid subsequent to June 30, 2012.

Wellmont has invested $10,000 in the preferred equity of a regional managed services organization and $1,512 on a right of first refusal related to any future sale of this organization. This equity has a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

Wellmont's investments are concentrated in stock and bond mutual funds. In the event of a downward trend in the stock and bond markets, Wellmont's overall market value of net assets could be adversely affected by a material amount. Investments in alternative investments are generally illiquid investments whose value is determined by the general partner such as hedge funds, private equity, commingled funds and real estate funds. Distributions are only at the discretion of a voting majority of the general partners.

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, Wellmont recognized other-than-temporary impairment losses of $265 and $610 on investments as of June 30, 2012 and 2011, respectively. The unrealized losses on these mutual funds were primarily caused by the overall decline in the world's economy. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

(Continued)

(Dollars in thousands)

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2012 and 2011, were as follows:

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2012:						
Alternative investments	$ 129	52	—	—	129	52
Mutual funds	2,692	55,142	2,903	15,407	5,595	70,549
	$ 2,821	55,194	2,903	15,407	5,724	70,601

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2011:						
Alternative investments	$ —	—	402	5,421	402	5,421
Mutual funds	616	75,091	9	158	625	75,249
	$ 616	75,091	411	5,579	1,027	80,670

Investment income comprises the following for the years ended June 30:

	2012	2011
Interest and dividends net of amounts capitalized	$ 10,371	9,407
Realized gains on investments	6,901	976
Investment income, net	$ 17,272	10,383
Change in net unrealized (losses) gains on investments	$ (9,534)	42,186

(Dollars in thousands)

(9) Land, Buildings, and Equipment

Land, buildings, and equipment at June 30 consist of the following:

	2012	2011
Land	$ 49,397	49,060
Buildings and improvements	526,243	509,382
Equipment	364,973	328,604
Buildings and equipment under capital lease obligations	42,404	39,661
	983,017	926,707
Less accumulated depreciation	(527,828)	(484,187)
	455,189	442,520
Construction in progress	2,859	12,417
Land, buildings, and equipment	$ 458,048	454,937

Depreciation expense for the years ended June 30, 2012 and 2011 was $46,359 and $46,070, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was $17,234 and $15,336 as of June 30, 2012 and 2011, respectively.

(10) Other Long-Term Liabilities

Other long-term liabilities at June 30 consist of the following:

	2012	2011
Workers' compensation liability	$ 9,097	7,812
Professional and general liability	12,535	12,830
Postretirement benefit obligation	7,039	7,763
Asset retirement obligation	2,994	2,912
Deferred gain on sale of assets	439	628
Derivative liability	9,781	11,588
Pension benefit liability	17,290	6,526
Other	667	852
	59,842	50,911
Less current portion	(5,782)	(8,527)
Total other long-term liabilities	$ 54,060	42,384

(Continued)

(Dollars in thousands)

(11) Debt

(a) Long-Term Debt

Long-term debt consists of the following at June 30:

	2012	2011
Hospital Revenue Refunding Bonds, Series 2011	$ 76,165	76,165
Hospital Revenue Bonds, Series 2010 (Bank Qualified)	24,836	14,968
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2005	57,250	59,580
Hospital Revenue Bonds, Series 2003	29,230	33,035
Notes payable	3,102	4,749
Capital lease obligations	18,514	16,889
Other	826	859
	464,923	461,245
Unamortized premium	7,005	7,287
Unamortized discount	(361)	(377)
	471,567	468,155
Less current maturities	(11,913)	(9,273)
	$ 459,654	458,882

(b) Series 2011 Bonds

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

The Series 2011 Bonds were issued with two maturities of $42,385 and $33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2013 and ending on September 1, 2026 in annual

amounts ranging from $865 to $4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from $4,980 to $6,300. The Series 2011 Bonds were issued as fixed-rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(c) Series 2010 Bank Qualified Bonds

On November 1, 2010, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (the Board) issued $30,000 Hospital Revenue Bonds, Series 2010 (Bank Qualified). The Series 2010 Bonds were issued and sold pursuant to the Bond Purchase Agreement dated as of November 1, 2010, between the Board and First Tennessee Bank National Association. During the fiscal year ended June 30, 2012 and 2011, Wellmont has received advances on the bonds in the amounts of $11,368 and $14,968, respectively.

Commencing on January 1, 2011, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Commencing on October 1, 2011 and continuing on the first day of each fiscal quarter thereafter, Wellmont shall also make principal payments equal to $500. The outstanding bonds accrue interest at a rate equal to the product of 65% of the sum of LIBOR plus the applicable margin, which at June 30, 2012 was set at 1.95%.

(d) Series 2007 Bonds

On July 24, 2007, The Virginia Small Business Financing Authority issued, on behalf of Wellmont, $55,000 of Hospital Revenue Bonds, Series 2007A. The Series 2007A Bonds, with other methods of financing, were used to purchase the assets of Mountain View Regional Medical Center and Lee Regional Medical Center.

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $360 to $2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of $29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.250%.

(e) Series 2006 C

On October 26, 2006, The Health, Educational, and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, $200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to: finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation and equipping of an operating room and related facilities at HCMH.

Principal on outstanding Series 2006C Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,605 to $25,330 commencing on September 1, 2017 through September 1, 2036. The outstanding bonds accrue interest at rates ranging from 5.00% to 5.25%.

(f) Series 2006 A and B

On June 23, 2006, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $98,475 of Hospital Revenue Refunding Bonds, Series 2006. This bond issuance consisted of Series A tax-exempt and Series B taxable bonds of $76,595 and $21,880, respectively. The Series 2006 Bonds together with other available funds were used to advance refund all the previously issued Hospital Revenue Bonds, Series 1993, to reimburse Wellmont for payments made on other taxable borrowings and to pay certain expenses incurred in connection with the issuance of the Series 2006 Bonds. Upon this refunding, a trust was established to pay all future bond payments related to the Series 1993 Bonds. Wellmont was deemed to have paid the Series 1993 Bonds and these Bonds are no longer deemed to be outstanding for purposes of the Series 1993 Trust Indenture.

Principal on outstanding Series 2006A Bonds was payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $875 to $6,400 commencing on September 1, 2013 through September 1, 2032; and the outstanding bonds accrued interest on a variable rate, which was reset monthly based upon the AAA-insured Municipal Market Data Index, plus 85 basis points. Principal on outstanding Series 2006B Bonds was payable through maturity in annual amounts ranging from $1,600 to $2,930 commencing on September 1, 2007 through September 1, 2016, and the outstanding bonds accrued interest at a fixed rate of 6.95%.

Outstanding Series 2006A Bonds were subject to redemption prior to maturity at the option of The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100% – 102% of the principal amount of the Series 2006A Bonds being redeemed, plus accrued interest thereon to the redemption date.

On October 1, 2010, the Series 2006B Bonds were called and paid in full at par value of $14,880.

On May 5, 2011, the Series 2006A Bonds were refunded with the proceeds of the Revenue Bonds, Series 2011.

(g) Series 2005

On December 8, 2005, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

Principal on outstanding Series 2005 Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,945 to $3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a "best efforts" basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate equal to the greater of (i) the Prime Rate plus 1.50% per annum, (ii) LIBOR plus 2.50% per annum, or (iii) 7.50% per annum. Wellmont shall repay the liquidity drawing amount in 12 equal quarterly installments, with the first such installment due on the first anniversary of the related liquidity drawing.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100% – 102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(h) Series 2003

On June 1, 2003, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont's Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of $27,460 in fixed-rate serial bonds and $19,280 in fixed-rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from $3,230 on September 1, 2007 to $4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

(i) Master Trust Indenture

The master trust indentures and loan agreements for the 2011, 2010, 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

(Dollars in thousands)

Funds held by the trustee related to the various revenue bonds are available for specific purposes. The bond interest and revenue funds may be used only to pay interest and principal on the bonds; the debt service reserve fund may be used to pay interest and principal if sufficient funds are not available in the bond interest and revenue funds. The original issue discount and premium on all Bond Series outstanding are being amortized over the life of the bond issue using the effective-interest method.

(j) Notes Payable

During 2007, Wellmont entered into a five-year $3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011. In August 2011, Wellmont renewed this note agreement in the amount of $1,760 with a variable interest rate indexed to the Wall Street Journal U.S. Prime Rate with a ceiling of 7.75% and a floor of 4.00% and a maturity date of August 2016. At June 30, 2012 and 2011, $1,540 and $1,784, respectively, was outstanding on this note.

During 2009, Wellmont entered into a five-year $2,400 term note payable with a variable interest rate indexed to the Wall Street Journal U.S. Prime Rate and a maturity date of October 2013. At June 30, 2012 and 2011, $640 and $1,120, respectively, was outstanding on this note.

During 2010, Wellmont entered into a $2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable has a fixed interest rate of 5.5% and a termination date of May, 2013. At June 30, 2012 and 2011, $922 and $1,845, respectively, was outstanding on this note.

(k) Capital Lease Obligations

Assets under capital leases are included in property and equipment and have a net carrying value of $25,170 and $24,325 as of June 30, 2012 and 2011, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 4.3% to 12.0%.

(l) Long-Term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2012 are as follows:

2013	$	11,913
2014		10,230
2015		10,294
2016		10,610
2017		11,253
Thereafter		410,623
	$	464,923

(Continued)

(Dollars in thousands)

The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2013	$	11,913
2014		21,390
2015		25,907
2016		26,103
2017		12,916
Thereafter		366,694
	$	464,923

Interest paid for the years ended June 30, 2012 and 2011 was $22,216 and $21,957, respectively, net of amounts capitalized. Interest costs of $0 and $590, net of interest income of $0 and $49 in 2012 and 2011, respectively, were capitalized.

(12) Derivative Transactions

Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to post collateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2012 and 2011, Wellmont was not required to post collateral related to its swaps.

Market risk is the adverse effect on the value of a derivative instrument that results from a change in interest rates. The market risk associated with interest-rate contracts is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

In September and October, 2008, the counterparty and credit support provider, for four of the swaps held at June 30, 2010, filed bankruptcy. Subsequent to the bankruptcy filings and into 2011, no payments were made by Wellmont or the counterparty to each other. During 2011, Wellmont and the counterparty agreed to settle all amounts due on the swaps for net cash flow receivables or payables. The bankruptcy process is underway and the ultimate outcome regarding any final settlement cannot be determined at this time.

Wellmont has a Total Return Swap on the Series 2011 Bonds with a new counterparty.

(Dollars in thousands)

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2012 and 2011 of approximately $(9,781) and $(11,588), respectively, is included in other long-term liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately $1,807 and $1,355, respectively, in 2012 and 2011 and is included in nonoperating gains (losses), net in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The following is a summary of the interest rate swap information as of June 30, 2012:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2011	$ 76,165	May 5, 2011	September 1, 2032	1.530%	6.200%	$ 2,888
Pay fixed interest rate swap	Series 2005	57,250	December 13, 2005	September 1, 2016	3.548	0.165	(6,471)
Basis swap	Series 2002	60,765	September 1, 2002	September 1, 2032	0.180	0.339	(1,662)
Pay fixed interest rate swap	*	32,880	October 24, 2003	September 1, 2021	3.613	0.165	(4,536)
							$ (9,781)

* Previously designated bond series has been refinanced.

The following is a schedule detailing the swap information as of June 30, 2011:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2011	$ 76,165	May 5, 2011	September 1, 2032	1.440%	6.200%	$ (377)
Pay fixed interest rate swap	Series 2005	59,580	December 13, 2005	September 1, 2016	3.548	0.124	(5,954)
Basis swap	Series 2002	62,730	September 1, 2002	September 1, 2032	0.090	0.181	(1,715)
Pay fixed interest rate swap	*	35,342	October 24, 2003	September 1, 2021	3.613	0.124	(3,542)
							$ (11,588)

* Previously designated bond series has been refinanced.

(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined-contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined-contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was $10,346 and $10,344 for the years ended June 30, 2012 and 2011, respectively.

HVMC sponsored a noncontributory, defined-benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined-benefit pension plan covering substantially all its employees.

HVMC's defined-pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined-pension plan exists. Collectively, the two defined-benefit plans are referred to as the "Plans." Effective June 30, 2010, the plan was frozen for all Lonesome Pine Hospital employees and no further benefits will be accrued.

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined-benefit pension plans as an asset or liability in its consolidated balance sheet and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined-benefit pension plans use a June 30 measurement date.

(Dollars in thousands)

The following table sets forth the funded status of the combined Plans, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		2012	2011
Change in benefit obligation:			
Benefit obligation at beginning of year	$	45,337	44,565
Service cost		—	220
Interest cost		2,422	2,390
Actuarial losses		8,614	896
Benefits paid		(2,292)	(2,239)
Curtailments *		—	(495)
Benefit obligation at end of year		54,081	45,337
Change in plan assets:			
Fair value of plan assets at beginning of year		38,811	34,547
Actual return on plan assets		(304)	6,503
Employer contribution		576	—
Benefits paid		(2,292)	(2,239)
Fair value of plan assets at end of year		36,791	38,811
Funded status	$	(17,290)	(6,526)
Amounts recognized in the accompanying consolidated balance sheets:			
Pension benefit liability (other long-term liabilities)	$	(17,290)	(6,526)

* Reflects frozen benefit accruals for Lonesome Pine participants as of June 30, 2011.

(Continued)

(Dollars in thousands)

		2012	2011
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:			
Unrecognized actuarial loss	$	19,773	8,565
Unrecognized prior service cost		—	—
Net amounts included as an accumulated charge to unrestricted net assets	$	19,773	8,565
Calculation of change in unrestricted net assets:			
Accumulated charge to unrestricted net assets, end of year	$	19,773	8,565
Reversal of accumulated charge to unrestricted net assets, prior year		(8,565)	(13,160)
Change in unrestricted net assets	$	11,208	(4,595)
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Prior service credit adjustment for curtailment	$	—	(1)
Actuarial loss (gain) arising during the year		11,577	(3,763)
Amortization of actuarial loss		(369)	(831)
Amortization of prior service cost		—	—
Net amounts recognized in unrestricted net assets	$	11,208	(4,595)

(Continued)

(Dollars in thousands)

		2012	2011
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2012:			
Amortization of net loss	$	2,186	382
Amortization of prior service cost		—	—
Estimated future benefit payments:			
Fiscal 2012		—	2,276
Fiscal 2013		2,609	2,369
Fiscal 2014		2,732	2,492
Fiscal 2015		2,821	2,596
Fiscal 2016		2,996	2,671
Fiscal 2017 – 2021		16,054	14,819
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		4.00%	5.50%
Weighted average rate of increase in future compensation levels		N/A	N/A
Components of net periodic benefit cost (benefit):			
Service cost	$	—	220
Interest cost		2,422	2,390
Expected return on plan assets		(2,658)	(2,340)
Amortization of net loss		369	831
Amortization of unrecognized prior service cost			
curtailments		—	1
Net periodic benefit cost	$	133	1,102
Weighted average assumptions used to determine net periodic benefit cost:			
Settlement (discount) rate		5.50%	5.50%
Expected long-term return on plan assets (HVMC)		7.00	7.00
Expected long-term return on plan assets (LPH)		7.00	7.00
Weighted average rate of increase in future compensation levels		N/A	3.00

Wellmont's overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont has developed a plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

(Continued)

(Dollars in thousands)

The table below shows the target allocation and actual asset allocations as of June 30, 2012 and 2011:

Asset	Target allocation	2012	2011
Equity securities	65%	47%	46%
Fixed income	28	32	35
Cash	5 – 15%	2	2
Other	5 – 15%	19	17

Wellmont monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

HVMC also participates in a health and welfare plan for its retirees. The plan provides postretirement medical and life insurance benefits to certain employees who meet minimum age and service requirements. Effective January 1, 1995, the death benefit was changed to provide a flat $5 benefit to all future retirees. During 1995, the medical program for retirees was amended to terminate medical benefits for any active employees who would not meet the full eligibility requirements of the program by January 1, 1996. The plan is contributory and contains other cost-sharing features such as deductibles and coinsurance.

The following table sets forth the postretirement plan's funded status, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

	Postretirement benefits	
	2012	2011
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 7,763	5,861
Interest cost	298	365
Plan participants contributions	34	79
Actuarial losses	(975)	1,686
Benefits paid	(81)	(228)
Benefit obligation at end of year	7,039	7,763
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	47	149
Plan participants contributions	34	79
Benefits paid	(81)	(228)
Fair value of plan assets at end of year	—	—
Funded status	$ 7,039	7,763

(Continued)

(Dollars in thousands)

	Postretirement benefits	
	2012	**2011**
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent assets	$ —	—
Current liabilities	(245)	(271)
Noncurrent liabilities	(6,794)	(7,492)
Accumulated charge to unrestricted net assets	2,469	1,755
	$ (4,570)	(6,008)

Amounts recognized as an accumulated credit to unrestricted net assets consist of:

	2012	**2011**
Net actuarial gain	$ 2,469	1,755

Net periodic benefic cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2012 and 2011 were:

	Postretirement benefits	
	2012	**2011**
Net periodic benefit cost:		
Interest cost	$ 299	365
Amortization of net gain	(262)	(119)
Net periodic benefit cost recognized	37	246
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	(975)	1,686
Amortization of net gain	262	119
Total recognized in unrestricted net assets	(713)	1,805
Total recognized in net periodic benefit cost and unrestricted net assets	$ (676)	2,051

(Continued)

(Dollars in thousands)

The net gain and prior service credit for the defined-benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $(168) and $(88), respectively. Weighted average assumptions used to determine benefit obligations for 2012 and 2011 were as follows:

	2012	2011
Discount rate	3.50%	5.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2012 and 2011 were as follows:

	Postretirement benefits	
	2012	2011
Discount rate	5.00%	5.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 5% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2012.

The following table summarizes the effect of one-percentage-point increase/decrease in healthcare costs trends:

		2012	2011
Effect of one-percentage-point increase in healthcare cost trend on:			
Service and interest cost	$	21	27
Accumulated pension benefit obligation		533	545
Effect of one-percentage-point decrease in healthcare cost trend on:			
Service and interest cost	$	(19)	(24)
Accumulated pension benefit obligation		(473)	(486)

(Continued)

(Dollars in thousands)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2012 and 2011, respectively, were as follows:

	Fair value measurement at June 30, 2012 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 29,223	29,223	—	—
Cash and money market funds	578	578	—	—
Alternative funds	6,990	—	3,443	3,547
Total	$ 36,791	29,801	3,443	3,547

	Fair value measurement at June 30, 2011 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 31,311	31,311	—	—
Cash and money market funds	632	632	—	—
Alternative funds	6,868	—	3,280	3,588
Total	$ 38,811	31,943	3,280	3,588

(Continued)

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2012 and 2011:

	Alternative investments
Balance at June 30, 2010	$ 5,500
Net change in value	1,349
Purchases, issuances, and settlements	19
Transfers in and/or out of Level 3 (net)	(3,280)
Balance at June 30, 2011	3,588
Net change in value	(29)
Purchases, issuances, and settlements	(12)
Transfers in and/or out of Level 3 (net)	—
Balance at June 30, 2012	$ 3,547

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers' compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont has established revocable self-insurance trust funds to provide for professional and general liability claims and workers' compensation claims and related expenses. Wellmont's contributions to the self-insurance trusts are based upon actuarial determinations by an independent service company. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Workers' compensation expense under these programs amounted to approximately $4,100 and $4,056 for the years ended June 30, 2012 and 2011, respectively, and are included in salaries and benefits expense in the accompanying consolidated statements of operations and changes in net assets. All other self-insurance expense under these programs amounted to approximately $2,763 and $3,097 for the years ended June 30, 2012 and 2011, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2012 and 2011, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2012 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2012 are adequate

(Dollars in thousands)

to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

Wellmont is also self-insured for medical and other healthcare benefits provided to its employees and their families. A provision for estimated incurred but not reported claims has been provided in the consolidated financial statements.

(15) Commitments and Contingencies

Construction in progress at June 30, 2012 and 2011 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately $2,768 at June 30, 2012. Wellmont has entered into contracts of $2,768 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was $19,391 and $18,179 for the years ended June 30, 2012 and 2011, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2012 are as follows:

2013	$	13,473
2014		7,613
2015		6,564
2016		4,527
2017		4,364
Thereafter		19,713
	$	56,254

Wellmont has entered into contractual employment relationships with physicians to provide services to Wellmont physician practices that are intended to qualify under the employee safe harbor of the Anti-Kickback Statute and the employee exception of the Physician Self-Referral Law. These contracts have terms of varying lengths, guarantee certain base payments, and may provide for additional incentives based upon productivity.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, such matters as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes Wellmont is in compliance with fraud and abuse statutes and other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

(Dollars in thousands)

(16) Functional Expense Disclosure

Wellmont provides healthcare services to residents within its geographic location. Expenses based upon functional classification related to providing these services during the years ended June 30 are as follows:

	2012	2011
Professional care of patients	$ 619,560	598,545
Administrative and general	146,740	142,768
Fund-raising	1,103	913
	$ 767,403	742,226

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately $84,000 at June 30, 2012, which begin expiring in fiscal 2018 and expire through 2032. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont Health System participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont Health System files a Form 990-T with the IRS to report such activity. Wellmont Health System has net operating loss carry forwards for federal income tax purposes of approximately $1,800 for unrelated business activities. Management believes that it is not more likely than not that deferred tax assets arising from net operating loss carry forwards will be realizable. Accordingly, these are fully reserved at June 30, 2012 and 2011.

(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2012 and 2011, was as follows:

	2012	2011
Medicare	50%	42%
TennCare	5	4
Medicaid	7	9
Other third-party payors	31	35
Patients	7	10
	100%	100%

(Continued)

(19) Disclosures about Fair Value of Financial Instruments

(a) Fair Value of Financial Instruments

The following methods and assumptions were used to estimate fair value of each class of instruments:

- *Cash and Cash Equivalents*

  The carrying amount approximates fair value due to the short maturities of these instruments.

- *Patient Accounts and Other Receivables*

  The net recorded carrying value approximates fair value due to the short maturities of these instruments.

- *Investments and Assets Limited as to Use*

  The fair values of investments and assets limited as to use are based on quoted market prices and quotes obtained from security brokers or, in the case of the limited partnerships, by the general partner.

- *Accounts Payable and Accrued Expenses*

  The carrying amount approximates fair value due to the short maturities of these liabilities.

- *Estimated Third-Party Payor Settlements, Other Long-Term Liabilities*

  The carrying amount approximates fair market value due to the nature of these liabilities.

- *Long-Term Debt*

  The fair value of revenue bonds, using current market rates, was estimated at $436,634 and $419,960 for the years ended June 30, 2012 and 2011, respectively.

(b) Fair Value Hierarchy

On July 1, 2008, Wellmont adopted new guidance issued by FASB for fair value measurement of financial assets and financial liabilities and for fair value measurement of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis now codified into ASC 820, *Fair Value Measurement*. ASC 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted market prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted market prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted market prices including within Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

Wellmont also applies the measurement provisions of ASU No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was $36,989 and $66,529 at June 30, 2012 and 2011, respectively.

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2012:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 44,930	—	—	44,930
Assets limited as to use:				
Stock mutual funds	88,942	—	—	88,942
Bond mutual funds	163,401	—	—	163,401
Cash and money market funds	44,240	—	—	44,240
Real estate funds	7,157	—	—	7,157
Alternative investments	—	—	36,989	36,989
Corporate bonds	2,673	—	—	2,673
U.S. Treasury bonds	—	—	—	—
Subtotal	351,343	—	36,989	388,332
Long-term investments:				
Stock mutual funds	10,321	—	—	10,321
Bond mutual funds	13,926	—	—	13,926
Cash and money market funds	189	—	—	189
Real estate funds	685	—	—	685
Alternative investments	—	—	—	—
Subtotal	25,121	—	—	25,121
	$ 376,464	—	36,989	413,453
Liabilities:				
Derivatives liability	$ —	9,781	—	9,781
Total	$ —	9,781	—	9,781

(Continued)

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2011:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 36,558	—	—	36,558
Assets limited as to use:				
Stock mutual funds	80,413	—	—	80,413
Bond mutual funds	119,836	—	—	119,836
Cash and money market funds	39,215	—	—	39,215
Real estate funds	8,475	—	—	8,475
Alternative investments	—	26,480	37,778	64,258
Corporate bonds	7,877	—	—	7,877
U.S. Treasury bonds	1,215	—	—	1,215
Subtotal	293,589	26,480	37,778	357,847
Long-term investments:				
Stock mutual funds	10,890	—	—	10,890
Bond mutual funds	10,741	—	—	10,741
Cash and money market funds	191	—	—	191
Real estate funds	832	—	—	832
Alternative investments	—	2,271	—	2,271
Subtotal	22,654	2,271	—	24,925
	$ 316,243	28,751	37,778	382,772
Liabilities:				
Derivatives liability	$ —	11,588	—	11,588
Total	$ —	11,588	—	11,588

(Continued)

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2012 and 2011:

		Alternative investments
Balance at June 30, 2010	$	39,362
Total realized and unrealized gains (losses):		
Included in revenues and gains in excess of expenses and losses		—
Included in changes in net assets		(3,401)
Purchases, issuances, and settlements		1,817
Transfers in and/or out of Level 3 (net)		—
Balance at June 30, 2011		37,778
Total realized and unrealized gains (losses):		
Included in revenues and gains in excess of expenses and losses		264
Included in changes in net assets		(420)
Purchases, issuances, and settlements		(633)
Transfers in and/or out of Level 3 (net)		—
Balance at June 30, 2012	$	36,989

(20) Subsequent Events

On September 7, 2012, Wellmont entered into a $55 million contract with a major information systems service provider to replace its clinical information systems. Wellmont expects to spend approximately $100 million on the project.

Wellmont has evaluated subsequent events from the balance sheet date through October 24, 2012, the date at which the financial statements were available to be issued. No other material subsequent events were identified for recognition.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2013 and 2012

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

Table of Contents

KPMG LLP
Suite 1000
401 Commerce Street
Nashville, TN 37219-2422

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Wellmont Health System and affiliates, which comprise the consolidated balance sheets as of June 30, 2013 and 2012, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Wellmont Health System and affiliates as of June 30, 2013 and 2012, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Nashville, Tennessee
October 23, 2013

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2013 and 2012

(Dollars in thousands)

Assets		2013	2012
Current assets:			
Cash and cash equivalents	$	55,958	44,930
Assets limited as to use, required for current liabilities		5,061	4,372
Patient accounts receivable, less allowance for uncollectible accounts of approximately $26,209 and $25,656 in 2013 and 2012, respectively		107,029	108,265
Other receivables		17,995	23,805
Inventories		18,361	17,862
Prepaid expenses and other current assets		8,949	7,462
Total current assets		213,353	206,696
Assets limited as to use, net of current portion		375,709	339,030
Land, buildings, and equipment, net		474,730	458,048
Other assets:			
Long-term investments		28,628	36,633
Investments in affiliates		31,874	32,646
Deferred debt expense, net		5,178	5,419
Goodwill		15,096	17,090
Other		547	651
		81,323	92,439
Total assets	$	1,145,115	1,096,213
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	15,002	11,913
Accounts payable and accrued expenses		84,300	81,243
Estimated third-party payor settlements		7,157	15,535
Current portion of other long-term liabilities		6,198	5,782
Total current liabilities		112,657	114,473
Long-term debt, less current portion		475,946	459,654
Other long-term liabilities, less current portion		41,567	54,060
Total liabilities		630,170	628,187
Net assets:			
Unrestricted		503,934	458,218
Temporarily restricted		6,927	5,739
Permanently restricted		1,311	1,304
Total net assets attributable to Wellmont		512,172	465,261
Noncontrolling interests		2,773	2,765
Total net assets		514,945	468,026
Commitments and contingencies			
Total liabilities and net assets	$	1,145,115	1,096,213

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2013 and 2012

(Dollars in thousands)

	2013	2012
Revenue:		
Patient service revenue	$ 809,517	811,882
Provision for bad debt	(55,029)	(71,407)
Net patient revenue less provision for bad debt	754,488	740,475
Other revenues	43,735	47,904
Total revenue	798,223	788,379
Expenses:		
Salaries and benefits	381,210	368,287
Medical supplies and drugs	163,922	164,350
Purchased services	80,179	78,732
Interest	21,833	21,677
Depreciation and amortization	51,319	46,369
Other	86,816	86,501
Total expenses	785,279	765,916
Income from operations	12,944	22,463
Nonoperating gains:		
Investment income	19,467	17,272
Derivative valuation adjustments	2,356	1,807
Nonoperating gains, net	21,823	19,079
Revenue and gains in excess of expenses and losses before discontinued operations	34,767	41,542
Discontinued operations	(2,167)	(52)
Revenue and gains in excess of expenses and losses	32,600	41,490
Income attributable to noncontrolling interests	(1,228)	(1,670)
Revenues and gains in excess of expenses and losses attributable to Wellmont	31,372	39,820
Other changes in unrestricted net assets:		
Change in net unrealized gains (losses) on investments	6,157	(9,534)
Net assets released from restrictions for additions to land, buildings, and equipment	828	3,766
Change in the funded status of benefit plans and other	7,359	(10,495)
Increase in unrestricted net assets	45,716	23,557
Changes in temporarily restricted net assets:		
Contributions	2,977	6,661
Net assets released from temporary restrictions	(1,789)	(4,492)
Increase in temporarily restricted net assets	1,188	2,169
Changes in permanently restricted net assets – investment income	7	130
Changes in noncontrolling interests:		
Income attributable to noncontrolling interests	1,228	1,670
Distributions to noncontrolling interests	(1,220)	(1,261)
Increase in noncontrolling interests	8	409
Change in net assets	46,919	26,265
Net assets, beginning of year	468,026	441,761
Net assets, end of year	$ 514,945	468,026

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2013 and 2012

(Dollars in thousands)

	2013	2012
Cash flows from operating activities:		
Change in net assets	$ 46,919	26,265
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	51,392	46,403
Loss (gain) on disposal of land, buildings, and equipment	211	(458)
Equity in earnings of affiliated organizations	(4,594)	(7,233)
Distributions from affiliated organizations	5,366	5,764
Amortization of deferred financing costs	486	428
Net realized and unrealized (gain) loss on investments	(9,580)	2,633
Provision for bad debts	55,029	71,407
Change in fair value of derivative instruments	(2,356)	(1,807)
Impairment of goodwill	2,007	—
Changes in assets and liabilities:		
Patient accounts receivable	(53,793)	(78,107)
Other current assets	(1,986)	(331)
Other assets	5,872	(13,920)
Accounts payable and accrued expenses	(2,532)	10,230
Estimated third-party payor settlements	(8,378)	6,002
Other current liabilities	416	(2,745)
Other liabilities	(10,137)	13,672
Net cash provided by operating activities	74,342	78,203
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	115,439	149,087
Purchase of investments	(135,222)	(174,029)
Purchase of land, buildings, and equipment	(57,747)	(46,026)
Proceeds from the sale of buildings and equipment	355	1,721
Cash paid for acquisitions	(13)	(813)
Net cash used in investing activities	(77,188)	(70,060)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	28,908	11,368
Payments on long-term debt	(14,789)	(11,139)
Payment of debt issuance costs	(245)	—
Net cash provided by financing activities	13,874	229
Net increase in cash and cash equivalents	11,028	8,372
Cash and cash equivalents, beginning of year	44,930	36,558
Cash and cash equivalents, end of year	$ 55,958	44,930

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of $5,262 and $3,281 in 2013 and 2012, respectively.

Additions to property and equipment financed through current liabilities of $5,589 and $2,487 in 2013 and 2012, respectively.

See accompanying notes to consolidated financial statements.

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont), a Tennessee not-for-profit corporation, currently operates seven community acute care hospitals in Tennessee and Virginia that include Bristol Regional Medical Center in Bristol, Tennessee, Holston Valley Medical Center in Kingsport, Tennessee, Lonesome Pine Hospital in Big Stone Gap, Virginia, Hawkins County Memorial Hospital in Rogersville, Tennessee, Hancock County Hospital in Sneedville, Tennessee, Lee Regional Medical Center in Pennington Gap, Virginia, and Mountain View Regional Medical Center in Norton, Virginia.

Wellmont also operates physician organizations and practices that are organized within Wellmont Medical Associates and Wellmont Cardiology Services.

As of May 17, 2013, a subsidiary of Wellmont ceased operating its sleep labs, which were managed by a third party. The consolidated financial statements for the year ended June 30, 2013 present the sleep labs as discontinued operations. The losses of $2,302, including an impairment loss of $2,007, and $140 for the years ended June 30, 2013 and 2012, respectively, are included in discontinued operations.

Wellmont's continuing operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

The consolidated financial statements include the operations of the above entities along with:

- Wellmont Foundation (the Foundation), which conducts fund-raising activities for the benefit of Wellmont
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection and medical laundry services, operate physician practices, provide other healthcare-related services, and invest in affiliates and other activities.

All significant intercompany accounts and transactions have been eliminated in the accompanying consolidated financial statements.

(2) Significant Accounting Policies

A summary of significant accounting policies is as follows:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) 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. Significant estimates include allowances for contractual adjustments and bad debts; third-party payor settlements; valuation of investments, land, buildings, equipment and goodwill; and self-insurance and other liabilities. Actual results could differ from these estimates.

(b) Cash and Cash Equivalents

Wellmont considers all highly liquid investments with a maturity of three months or less when purchased, excluding amounts whose use is limited by board of directors' designation or other arrangements under trust agreements, to be cash equivalents.

(c) Investments

Marketable equity securities and debt securities are recorded at fair value and classified as other than trading. Fair value is determined primarily using quoted prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date. However, Wellmont also uses observable and unobservable inputs for investments without quoted market prices to determine the fair value of certain investments at the measurement date. Investments in limited partnerships are recorded at fair value as determined by the partnership using net asset value. Wellmont has adopted the measurement provisions of Accounting Standards Update (ASU) No. 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. Investments in affiliates in which Wellmont has significant influence but does not control are reported on the equity method of accounting, which represents Wellmont's equity in the underlying net book value. Long-term investments include those investments that have not been designated by the board of directors for specific purposes and are also not intended to be used for the liquidation of current liabilities. Investment income is recognized when earned.

Realized gains and losses are determined on the specific-identification method and included in investment income with interest and dividends. Investment income is reported net of related investment fees. Unrealized gains and losses are included in other changes in unrestricted net assets except for losses determined to be other than temporary, which are considered realized losses and included in investment income.

(d) Assets Limited as to Use

Assets limited as to use primarily include assets held by trustees under bond indenture and self-insurance agreements, as well as designated assets set aside by the board of directors for future capital improvements, over which the board of directors retains control and may, at its discretion, subsequently use for other purposes. Amounts required to meet current liabilities of Wellmont have been reclassified to current assets in the accompanying consolidated balance sheets.

(e) Inventories

Inventories are stated at the lower of cost or market value and are valued principally by the first-in, first-out and average-cost methods.

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, if purchased, or fair value at date of donation. Depreciation is computed using the straight-line method based on the estimated useful life of the

asset, ranging from 3 to 40 years. Buildings and equipment held under capital leases are recorded at net present value of future lease payments and are amortized on a straight-line basis over the shorter of the lease term or estimated useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Upon sale or retirement of land, buildings, or equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss, if any, is included in other revenues on the consolidated statements of operations and changes in net assets. 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.

Wellmont evaluates long-lived assets for impairment on annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset.

(g) Goodwill

Wellmont adopted ASU No. 2010-07, *Not for Profit Entities: Mergers and Acquisitions*, which in part requires healthcare entities to follow Accounting Standards Codification (ASC) Topic 350-20-35, *Intangibles – Goodwill and Other* along with ASU 2011-08, *Testing Goodwill for Impairment,* effective July 1, 2012. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. An entity has the option to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If, after assessing the totality of events or circumstances, an entity determines it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. The more-likely than-not threshold is defined as having a likelihood of more than 50 percent. However, if an entity concludes otherwise, then it is required to perform the first step of the two-step impairment test by calculating the fair value of the reporting unit and comparing the fair value with the carrying amount (including goodwill) of the reporting unit. If the carrying amount of a reporting unit exceeds its fair value, then the entity is required to perform the second step of the goodwill impairment test to measure the amount of the impairment loss. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step

(Dollars in thousands)

two does not need to be performed. The annual impairment test is performed as of June 30. A summary of goodwill for the years ended June 30 is as follows:

	2012	Additions	Decreases	2013
Goodwill	$ 17,090	13	(2,007)	15,096

	2011	Additions	Decreases	2012
Goodwill	$ 16,721	369	—	17,090

(h) Deferred Debt Expense

Deferred debt expense is amortized over the life of the related bond issues using the effective-interest method.

(i) Derivative Financial Instruments

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) Asset Retirement Obligations

Asset retirement obligations (AROs) are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value, and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, Wellmont records period-to-period changes in the ARO liability resulting from the passage of time and revisions to either the timing or the amount of the original estimate of undiscounted cash flows. Wellmont derecognizes ARO liabilities when the related obligations are settled.

(k) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by Wellmont has been limited by donors to a specific-time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by Wellmont in perpetuity. Generally, donors of permanently restricted assets permit use of all or part of the income earned on related investments for general or specific purposes.

Temporarily restricted net assets relate primarily to amounts held by the Foundation and include amounts restricted for future capital expenditures and for operations of such areas as children's healthcare services, hospice, and cancer care.

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2013 and 2012 primarily included amounts related to the purchase of equipment for pediatrics, cancer, and other healthcare operations.

Wellmont has adopted guidance issued by Financial Accounting Standards Board (FASB), which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA). Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of five individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. On the basis of historical experience, a significant portion of Wellmont's uninsured patients will be unable or unwilling to pay for the services provided. Therefore, Wellmont records a significant provision for bad debts related to uninsured patients in the period the services are provided. This provision for bad debts is presented on the statement of operations as a component of net patient revenue. Wellmont provides care to patients who meet criteria under its charity care

policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

Patient accounts receivable are reported net of both an allowance for contractual adjustments and an allowance for uncollectible accounts. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, TennCare, Medicaid, and other third-party payment programs. Wellmont's policy does not require collateral or other security for patient accounts receivable. Wellmont routinely obtains assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans, or policies.

(m) Revenue and Gains in Excess of Expenses and Losses

The consolidated statements of operations and changes in net assets include revenue and gains in excess of expenses and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include changes in net unrealized gains (losses) on investments other than trading securities, changes in the funded status of Wellmont's defined-benefit plan, contributions of long-lived assets, including assets acquired using contributions that, by donor restriction, were to be used for the purposes of acquiring such assets, and cumulative effects of changes in accounting principles.

For purposes of financial statement display, those activities directly associated with Wellmont's mission of providing healthcare services are considered to be operating activities. Nonoperating activities primarily include investment and related activities. Other operating revenues primarily include cafeteria, rental, meaningful use incentives, and income from affiliates.

(n) Contributed Resources

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted contributions, and are excluded from revenue and gains in excess of expenses and losses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. Gifts are reported as either a temporarily or permanently restricted contribution if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions. Unrestricted contributions are included in other revenues.

(o) Federal Income Taxes

The Wellmont entities are primarily classified as organizations exempt from federal income taxes under Section 501(a) as entities described in Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been included for these entities in the consolidated financial statements. The operations of Wellmont, Inc. are subject to state and federal income taxes, which are accounted for in accordance with ASC Topic 740, *Income Taxes*; however, such amounts are not material.

On July 1, 2007, Wellmont adopted new guidance issued on the accounting for uncertainty in income tax positions now codified into ASC 740. It also provides guidance on when tax positions are recognized in an entity's financial statements and how the values of these positions are determined. There was no impact on Wellmont's consolidated financial statements as a result of the adoption of the new guidance.

(p) Recently Adopted Accounting Standards

The FASB issued ASU No. 2011-04, *Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs*, in May 2011. This ASU requires the reason for the fair value measurement to be disclosed, a description of the valuation techniques, and descriptions of the inputs used for all Level 2 and Level 3 fair value measurements. It also requires all transfers between levels of the fair value hierarchy to be separately reported and described. Wellmont adopted ASU 2011-04 as of July 1, 2012.

(q) Reclassifications

Certain 2012 amounts have been reclassified to conform to the 2013 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

(Dollars in thousands)

(3) 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 consolidated statements of operations and changes in net assets is as follows for the years ended June 30:

		2013	2012
Gross patient service revenue	$	2,517,774	2,396,167
Less:			
Contractual adjustments and other discounts		(1,646,455)	(1,522,625)
Charity care		(61,802)	(61,660)
Net patient service revenue before provision for bad debts		809,517	811,882
Less provision for bad debts		(55,029)	(71,407)
Net patient service revenue	$	754,488	740,475

Wellmont's allowance for doubtful accounts is predominantly for self-pay patients and patient balances remaining after third-party payments. The provision for bad debts decreased $16,378 from fiscal 2012 to fiscal 2013 and the net write-offs decreased $15,521 from fiscal 2012 to fiscal 2013. Both decreases were the result of significant decreases in inpatient and emergency room volumes, which are the primary source of patients with bad debt. Wellmont has not changed its charity care or uninsured discount policies during fiscal 2013. Wellmont does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(4) Third-Party Reimbursement Arrangements

Wellmont renders services to patients under contractual arrangements with the Medicare and Medicaid programs. The Medicaid program in Tennessee is a managed care program known as TennCare, which is designed to cover Medicaid eligible enrollees. Amounts earned under these contractual arrangements are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Management believes that adequate provision has been made for any adjustments that may result from such reviews. Participation in these programs subjects Wellmont to significant rules and regulations; failure to adhere to such could result in fines, penalties, or expulsion from the programs.

Wellmont contracts with various managed care organizations under the TennCare program. TennCare reimbursement for both inpatient and outpatient services is based upon prospectively determined rates, including diagnostic-related group assignments, fee schedules, and per diem amounts. Reimbursement under the Medicaid program is also based upon prospectively determined amounts.

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and

(Dollars in thousands)

medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid-eligible and other low-income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

Net patient service revenue in 2013 and 2012 related to Medicare, TennCare, and Medicaid and net patient accounts receivable at June 30, 2013 and 2012 from Medicare, TennCare, and Medicaid were as follows:

		2013	2012
Net patient service revenue:			
Medicare	$	303,694	312,202
TennCare		28,749	28,548
Medicaid		30,413	19,541
Net patient accounts receivable:			
Medicare	$	44,702	41,883
TennCare		3,298	2,957
Medicaid		6,980	5,244

Wellmont has filed cost reports with Medicare and Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2007 and audit adjustments have been received and considered for certain hospitals and year-ends through June 30, 2011.

Wellmont has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, per diem rates, and discounts from established charges.

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately $6,605 and $3,575 in 2013 and 2012, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2013 could differ materially from actual settlements based on the results of third-party audits.

(5) Meaningful Use Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record (EHR) technology. The Medicare incentive payments are paid out to qualifying

hospitals and physician groups over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals, and physician groups must meet EHR "meaningful use" criteria that become more stringent over three stages as determined by Centers for Medicare & Medicaid Services (CMS). Medicaid programs and payment schedules vary from state to state.

For fiscal years ending June 30, 2013 and 2012, Wellmont recorded $13,707 and $13,177, respectively, in other operating revenue related to the EHR and meaningful use incentives. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

Amounts recognized represent management's best estimates for payments ultimately expected to be received based on estimated discharges, charity care, and other input data. Subsequent changes to these estimates will be recognized in other operating revenue in the period in which additional information is available. Such estimates are subject to audit by the federal government or its designee.

(6) Charity Care and Community Services

Wellmont accepts all patients within its primary service area regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies that consider, among other factors, generally recognized poverty income levels.

Wellmont maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone and estimated costs incurred for services and supplies furnished under its charity care policy. Costs incurred are estimated based on the ratio of total operating expenses to gross charges applied to charity care charges. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were $61,802, $15,536, and 2.45%, respectively, for the year ended June 30, 2013 and $61,660, $16,144, and 2.57%, respectively, for the year ended June 30, 2012.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and State indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled $37,999 and $44,432, for the years ended June 30, 2013 and 2012, respectively.

Wellmont also provides services to the community at large for which it receives little or no payment. Health evaluations, screening programs, and specific services for the elderly and homebound are other services supplied. Wellmont also provides public health education, trains new health professionals, and conducts health research.

(7) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately $4,594 and $7,233 for the years ended June 30, 2013 and 2012, respectively, and is included in other operating

(Dollars in thousands)

revenue in the consolidated financial statements. Wellmont received distributions of $5,366 and $5,764 during 2013 and 2012, respectively, which reduced Wellmont's overall investment in the affiliates.

The following table summarizes the unaudited aggregate financial information of Wellmont's investments in affiliates:

		2013	2012
Total assets	$	135,802	127,206
Total liabilities		40,617	27,732
Total net assets	$	95,185	99,474
Net revenues	$	200,765	228,644
Expenses		186,394	207,806
Revenues in excess of expenses	$	14,371	20,838

Wellmont's investment in these affiliates and its ownership percentage as of June 30, 2013 and 2012 is as follows:

		Amount		Percentage	
		2013	2012	2013	2012
Takoma Regional Hospital	$	11,983	12,350	60%	60%
Holston Valley Imaging Center (HVIC)		8,336	8,818	75	75
Advanced Home Care (AHC)		6,092	6,092	6	6
Lab Group Holdings LLC		3,500	3,500	1	1
Others		1,963	1,886	4%–50%	4%–50%
	$	31,874	32,646		

Although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC is greater than 50%, Wellmont does not consolidate these entities because Wellmont only has a 50% representation on each respective board and does not have control over these entities.

Wellmont provided billing, management, and professional services to some of the affiliates. Income recognized by Wellmont for the services was $971 in 2013 and $929 in 2012 and is included in other revenues.

Included in other receivables are $406 and $374 as of June 30, 2013 and 2012, respectively, of amounts due to Wellmont from these entities.

(Dollars in thousands)

(8) Investments

Long-term investments, including assets limited as to use, at June 30 are reported at fair value and consist of the following:

	2013	2012
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	$ 109,356	88,942
Bond mutual funds	175,594	163,401
Cash and money market funds	3,749	1,492
Real estate funds	16,377	7,157
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	10,504	9,616
Illiquid	26,016	27,373
	341,596	297,981
Assets limited as to use under self-insurance agreements:		
Corporate bonds	—	2,673
Cash and money market funds	—	32
	—	2,705
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	39,174	42,716
Less assets limited as to use that are required for current liabilities	5,061	4,372
Assets limited as to use, net of current portion	$ 375,709	339,030
Long-term investments:		
Stock mutual funds	$ 12,228	10,321
Bond mutual funds	13,478	13,926
Preferred equity investment and related options	1,512	11,512
Cash, money market funds, and certificates of deposit	190	189
Real estate funds	1,220	685
Total long-term investments	$ 28,628	36,633

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately $5,229 as of June 30, 2013 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which $117 was paid subsequent to June 30, 2013.

Effective June 27, 2013, Wellmont redeemed its $10,000 in the preferred equity of a regional managed services organization; however, retained its $1,512 on a right of first refusal related to any future sale of

(Dollars in thousands)

this organization. This equity had a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

Wellmont's investments are concentrated in stock and bond mutual funds. In the event of a downward trend in the stock and bond markets, Wellmont's overall market value of net assets could be adversely affected by a material amount. Investments in alternative investments are generally illiquid investments whose value is determined by the general partner such as hedge funds, private equity, commingled funds, and real estate funds. Distributions are only at the discretion of a voting majority of the general partners.

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, Wellmont recognized other-than-temporary impairment losses of $131 and $265 on investments as of June 30, 2013 and 2012, respectively. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2013 and 2012 were as follows:

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2013:						
Alternative investments	$ 478	3,243	—	—	478	3,243
Mutual funds	7,304	181,780	371	3,185	7,675	184,965
	$ 7,782	185,023	371	3,185	8,153	188,208

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2012:						
Alternative investments	$ 129	52	—	—	129	52
Mutual funds	2,692	55,142	2,903	15,407	5,595	70,549
	$ 2,821	55,194	2,903	15,407	5,724	70,601

Investment income comprises the following for the years ended June 30:

	2013	2012
Interest and dividends, net of amounts capitalized	$ 16,044	10,371
Realized gains on investments, net	3,423	6,901
Investment income, net	$ 19,467	17,272
Change in net unrealized gains (losses) on investments	$ 6,157	(9,534)

(Dollars in thousands)

(9) Land, Buildings, and Equipment

Land, buildings, and equipment at June 30 consist of the following:

	2013	2012
Land	$ 49,758	49,397
Buildings and improvements	536,758	526,243
Equipment	384,747	364,973
Buildings and equipment under capital lease obligations	45,102	42,404
	1,016,365	983,017
Less accumulated depreciation	(576,210)	(527,828)
	440,155	455,189
Construction in progress	34,575	2,859
Land, buildings, and equipment	$ 474,730	458,048

Depreciation expense for the years ended June 30, 2013 and 2012 was $51,350 and $46,393, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was $18,408 and $17,234 as of June 30, 2013 and 2012, respectively.

(10) Other Long-Term Liabilities

Other long-term liabilities at June 30 consist of the following:

	2013	2012
Workers' compensation liability	$ 9,882	9,097
Professional and general liability	11,492	12,535
Postretirement benefit obligation	4,582	7,039
Asset retirement obligation	2,969	2,994
Deferred gain on sale of assets	439	439
Derivative liability	7,425	9,781
Pension benefit liability	10,393	17,290
Other	583	667
	47,765	59,842
Less current portion	(6,198)	(5,782)
Total other long-term liabilities	$ 41,567	54,060

(Continued)

(Dollars in thousands)

(11) Debt

(a) Long-Term Debt

Long-term debt consists of the following at June 30:

	2013	2012
Hospital Revenue Refunding Bonds, Series 2011	$ 76,165	76,165
Hospital Revenue Bonds, Series 2010 (Bank Qualified)	22,836	24,836
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2005	54,820	57,250
Hospital Revenue Bonds, Series 2003	25,225	29,230
Project Odyssey 2012 Tax-Exempt Master Lease/Sublease	16,150	—
Notes payable	11,968	3,102
Capital lease obligations	21,601	18,514
Other	847	826
	484,612	464,923
Unamortized premium	6,679	7,005
Unamortized discount	(343)	(361)
	490,948	471,567
Less current maturities	(15,002)	(11,913)
	$ 475,946	459,654

(b) Series 2011 Bonds

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

The Series 2011 Bonds were issued with two maturities of $42,385 and $33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the

redemption dates beginning on September 1, 2013 and ending on September 1, 2026 in annual amounts ranging from $865 to $4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from $4,980 to $6,300. The Series 2011 Bonds were issued as fixed-rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(c) Series 2010 Bank Qualified Bonds

On November 1, 2010, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (the Board) issued $30,000 Hospital Revenue Bonds, Series 2010 (Bank Qualified). The Series 2010 Bonds were issued and sold pursuant to the Bond Purchase Agreement dated as of November 1, 2010, between the Board and First Tennessee Bank National Association. During the fiscal years ended June 30, 2013 and 2012, Wellmont has received advances on the bonds in the amounts of $0 and $11,368, respectively.

Commencing on January 1, 2011, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Commencing on October 1, 2011 and continuing on the first day of each fiscal quarter thereafter, Wellmont shall also make principal payments equal to $500. The outstanding bonds accrue interest at a rate equal to the product of 65% of the sum of LIBOR plus the applicable margin, which at June 30, 2013 was set at 1.95%.

(d) Series 2007 Bonds

On July 24, 2007, The Virginia Small Business Financing Authority issued, on behalf of Wellmont, $55,000 of Hospital Revenue Bonds, Series 2007A. The Series 2007A Bonds, with other methods of financing, were used to purchase the assets of Mountain View Regional Medical Center and Lee Regional Medical Center.

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $360 to $2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of $29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.250%.

(e) Series 2006 C

On October 26, 2006, The Health, Educational, and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, $200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation and equipping of an operating room and related facilities at Hawkins County Memorial Hospital.

Principal on outstanding Series 2006C Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,605 to $25,330 commencing on September 1, 2017 through September 1, 2036. The outstanding bonds accrue interest at rates ranging from 5.00% to 5.25%.

(f) Series 2005

On December 8, 2005, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds.

Principal on outstanding Series 2005 Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,945 to $3,390 commencing on September 1, 2007 through September 1, 2032. The terms of the bonds provide that bondholders may redeem or put the bonds to the remarketing agent on dates that approximate a weekly basis. The remarketing agent is obligated to remarket the redeemed bonds on a "best efforts" basis. Redeemed bonds are repaid to bondholders from the proceeds of the remarketing effort or, in the event of an inability to remarket the bonds, from a letter of credit. This letter secures the bonds in the event of a failed remarketing or liquidity issue. In the event of a liquidity drawing under the letter of credit, Wellmont shall pay the Base Rate equal to the greater of (i) the Prime Rate plus 1.50% per annum, (ii) LIBOR plus 2.50% per annum, or (iii) 7.50% per annum. Wellmont shall repay the liquidity drawing amount in 12 equal quarterly installments, with the first such installment due on the first anniversary of the related liquidity drawing.

Outstanding Series 2005 Bonds are subject to redemption prior to maturity at the option of The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, upon direction by Wellmont in whole at any time, or in part on any certain specified days at redemption prices of 100%-102% of the principal amount of the Series 2005 Bonds being redeemed, plus accrued interest thereon to the redemption date.

(g) Series 2003

On June 1, 2003, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont's Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of $27,460 in fixed-rate serial bonds and $19,280 in fixed-rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from $3,230 on September 1, 2007 to $4,140 on September 1, 2019, and carrying interest rates ranging from 2.5% to 5.00%.

(h) Master Trust Indenture

The master trust indentures and loan agreements for the 2011, 2010, 2007, 2006, 2005, and 2003 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

Funds held by the trustee related to the various revenue bonds are available for specific purposes. The bond interest and revenue funds may be used only to pay interest and principal on the bonds; the debt service reserve fund may be used to pay interest and principal if sufficient funds are not available in the bond interest and revenue funds. The original issue discount and premium on all Bond Series outstanding are being amortized over the life of the bond issue using the effective-interest method.

(i) Project Odyssey 2012 Tax-Exempt Master Lease/Sublease Financing

On December 1, 2012, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (as Lessee) and Wellmont (as Sub-Lessee) entered into a Master Equipment Lease and Sublease Agreement with Banc of America Public Capital Corp (the Lessor). The proceeds of this Master Lease are being used to finance an electronic medical records system consisting of an EpicCare Inpatient Clinical System and an EpicCare Ambulatory Electronic Medical Records System inclusive of hardware, software, and implementation services subject to a License and Support agreement between Epic Systems Corporate and Sub-lessees dated September 19, 2012. The Sub-Lessee has authorized the Lessor to take a security interest in the entire System although only certain components of the System are to be funded under this Master Lease with the rest to be funded by Bank of America N.A. and Sub-Lessee. During the fiscal year ended June 30, 2013, Wellmont has received two advances totaling $16,150.

Each Lease Term shall commence and interest shall begin to accrue on the date any funds are advanced by the Lessor. The Lease payments shall be payable on a monthly basis. The first six lease payments under each agreement shall consist only of an interest component and the remaining 78 lease payments shall consist of a principal component and an interest component. Commencing on June 30, 2013, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Each agreement will have an interest component based on a fixed-rate of interest and payable with respect to the amount of funds that the Lessor has advanced. The Leases issued during the fiscal year ended June 30, 2013 as fixed-rate obligations calculated at 0.65% if the Average Life Swap Rate, United States Treasury Swap as of

(Dollars in thousands)

the Request date plus 1.0635% based on Lessor's credit evaluation of Wellmont, which resulted in 1.45% and 1.82% for the two maturities in 2020.

(j) Notes Payable

During 2007, Wellmont entered into a five-year $3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011. In August 2011, Wellmont renewed this note agreement in the amount of $1,760 with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate with a ceiling of 7.75% and a floor of 4.00% and a maturity date of August 2016. At June 30, 2013 and 2012, $1,199 and $1,540, respectively, were outstanding on this note.

During 2009, Wellmont entered into a five-year $2,400 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of October 2013. At June 30, 2013 and 2012, $379 and $640, respectively, were outstanding on this note.

During 2010, Wellmont entered into a $2,767 note payable to finance the purchase of Cardiovascular Associates. The note payable had a fixed interest rate of 5.5% and a termination date of May 2013. At June 30, 2013 and 2012, $0 and $922, respectively, were outstanding on this note.

On October 17, 2012, Wellmont entered into a ten-year $12,500 term note payable with Bank of America, N.A. The proceeds were used for the EpicCare system and its implementation, among other general corporate purposes. The note payable has a fixed interest rate of 3.27% and a maturity date of December 13, 2022. At June 30, 2013, $10,390 was outstanding on this note.

***(k)* Capital Lease Obligations**

Assets under capital leases are included in property and equipment and have a net carrying value of $26,695 and $25,170 as of June 30, 2013 and 2012, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 2.03% to 12.0%.

(l) Long-Term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2013 are as follows:

2014	$	15,002
2015		14,450
2016		14,124
2017		13,677
2018		16,182
Thereafter		411,177
	$	484,612

(Continued)

(Dollars in thousands)

The following table reflects the required repayment terms for the years ended June 30 of Wellmont's debt obligations in the event that the put options associated with the 2005 bonds were exercised, but not successfully remarketed.

2014	$	12,457
2015		30,064
2016		29,617
2017		29,045
2018		12,766
Thereafter		370,663
	$	484,612

Interest paid for the years ended June 30, 2013 and 2012 was $21,163 and $22,216, respectively, net of amounts capitalized. Interest costs of $299 and $0, net of interest income of $0 and $0 in 2013 and 2012, respectively, were capitalized.

(12) Derivative Transactions

Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to post collateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2013 and 2012, Wellmont was not required to post collateral related to its swaps.

Market risk is the adverse effect on the value of a derivative instrument that results from a change in interest rates. The market risk associated with interest-rate contracts is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

Wellmont has a Total Return Swap on the Series 2011 Bonds with a new counterparty.

(Dollars in thousands)

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2013 and 2012 of approximately $(7,425) and $(9,781), respectively, is included in other long-term liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately $2,356 and $1,807, respectively, in 2013 and 2012 and is included in nonoperating gains in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The following is a summary of the interest rate swap information as of June 30, 2013:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2011	$ 76,165	May 5, 2011	September 1, 2032	1.400%	6.222%	$ 1,792
Pay fixed interest rate swap	Series 2005	54,820	December 13, 2005	September 1, 2016	3.548	0.082	(4,738)
Basis swap	Series 2002	58,680	September 1, 2002	September 1, 2032	0.050	0.163	(1,245)
Pay fixed interest rate swap	*	30,295	October 24, 2003	September 1, 2021	3.613	0.082	(3,234)
							$ (7,425)

* Previously designated bond series has been refinanced.

The following is a schedule detailing the swap information as of June 30, 2012:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2011	$ 76,165	May 5, 2011	September 1, 2032	1.530%	6.200%	$ 2,888
Pay fixed interest rate swap	Series 2005	57,250	December 13, 2005	September 1, 2016	3.548	0.165	(6,471)
Basis swap	Series 2002	60,765	September 1, 2002	September 1, 2032	0.180	0.339	(1,662)
Pay fixed interest rate swap	*	32,880	October 24, 2003	September 1, 2021	3.613	0.165	(4,536)
							$ (9,781)

* Previously designated bond series has been refinanced.

In September and October 2008, the counterparty and credit support provider, for four of the swaps held at that time, filed bankruptcy. The bankruptcy process is underway and the ultimate outcome regarding any final settlement cannot be determined at this time.

(13) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined-contribution retirement plan (Retirement Plan) that covers substantially all employees. This program and the related Retirement Plan were created from amendments, restatements, and mergers of existing defined-contribution plans at BRMC and HVMC. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 3% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 3% of each participant's wages. The total pension expense related to the Retirement Plan was $13,020 and $10,346 for the years ended June 30, 2013 and 2012, respectively.

HVMC sponsored a noncontributory, defined-benefit pension plan covering substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. LPH also sponsors a defined-benefit pension plan covering substantially all its employees.

HVMC's defined-pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. HVMC's funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. The LPH plan contains similar funding and actuarial policies.

On June 30, 2007, the HVMC plan merged into LPH plan and the plan name changed to Wellmont Health System Defined Benefit Plan. At the end of 2008, only a single defined-pension plan exists. Collectively, the two defined-benefit plans are referred to as the "Plans." Effective June 30, 2010, the plan was frozen for all Lonesome Pine Hospital employees and no further benefits will be accrued.

Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined-benefit pension plans as an asset or liability in its consolidated balance sheet and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. All defined-benefit pension plans use a June 30 measurement date.

(Dollars in thousands)

The following table sets forth the funded status of the combined Plans, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		2013	2012
Change in benefit obligation:			
Benefit obligation at beginning of year	$	54,081	45,337
Service cost		—	—
Interest cost		2,102	2,422
Actuarial losses		(3,062)	8,614
Benefits paid		(2,372)	(2,292)
Benefit obligation at end of year		50,749	54,081
Change in plan assets:			
Fair value of plan assets at beginning of year		36,791	38,811
Actual return on plan assets		2,521	(304)
Employer contribution		3,417	576
Benefits paid		(2,372)	(2,292)
Fair value of plan assets at end of year		40,357	36,791
Funded status	$	(10,393)	(17,290)
Amounts recognized in the accompanying consolidated balance sheets:			
Pension benefit liability (other long-term liabilities)	$	(10,393)	(17,290)

(Continued)

(Dollars in thousands)

		2013	2012
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:			
Unrecognized actuarial loss	$	14,552	19,773
Unrecognized prior service cost		—	—
Net amounts included as an accumulated charge to unrestricted net assets	$	14,552	19,773
Calculation of change in unrestricted net assets:			
Accumulated charge to unrestricted net assets, end of year	$	14,552	19,773
Reversal of accumulated charge to unrestricted net assets, prior year		(19,773)	(8,565)
Change in unrestricted net assets	$	(5,221)	11,208
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Actuarial loss (gain) arising during the year	$	(3,003)	11,577
Amortization of actuarial loss		(2,218)	(369)
Amortization of prior service cost		—	—
Net amounts recognized in unrestricted net assets	$	(5,221)	11,208

(Continued)

(Dollars in thousands)

		2013	2012
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2013:			
Amortization of net loss	$	1,467	2,186
Amortization of prior service cost		—	—
Estimated future benefit payments:			
Fiscal 2013	$	—	2,609
Fiscal 2014		2,590	2,732
Fiscal 2015		2,658	2,821
Fiscal 2016		2,741	2,897
Fiscal 2017		2,828	2,996
Fiscal 2018–2022		18,643	16,054
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		4.50%	4.00%
Weighted average rate of increase in future compensation levels		N/A	N/A
Components of net periodic benefit cost (benefit):			
Service cost	$	—	—
Interest cost		2,102	2,422
Expected return on plan assets		(2,581)	(2,658)
Amortization of net loss		2,218	369
Net periodic benefit cost	$	1,739	133
Weighted average assumptions used to determine net periodic benefit cost:			
Settlement (discount) rate		4.00%	5.50%
Expected long-term return on plan assets (HVMC)		7.00	7.00
Expected long-term return on plan assets (LPH)		7.00	7.00
Weighted average rate of increase in future compensation levels		N/A	N/A

Wellmont's overall expected long-term rate of return on assets is 7.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont has developed a plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

(Continued)

(Dollars in thousands)

The table below shows the target allocation and actual asset allocations as of June 30, 2013 and 2012:

Asset	Target allocation	2013	2012
Equity securities	65%	48%	47%
Fixed income	28	33	32
Cash	5%–15%	1	2
Other	5%– 5%	18	19

Wellmont monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

HVMC also participates in a health and welfare plan for its retirees. The plan provides postretirement medical and life insurance benefits to certain employees who meet minimum age and service requirements. Effective January 1, 1995, the death benefit was changed to provide a flat $5 benefit to all future retirees. During 1995, the medical program for retirees was amended to terminate medical benefits for any active employees who would not meet the full eligibility requirements of the program by January 1, 1996. The plan is contributory and contains other cost-sharing features such as deductibles and coinsurance.

The following table sets forth the postretirement plan's funded status, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

	Postretirement benefits	
	2013	2012
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 7,039	7,763
Interest cost	163	298
Plan participants contributions	19	34
Actuarial losses	(2,554)	(975)
Benefits paid	(85)	(81)
Benefit obligation at end of year	4,582	7,039
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	66	47
Plan participants contributions	19	34
Benefits paid	(85)	(81)
Fair value of plan assets at end of year	—	—
Funded status	$ 4,582	7,039

(Continued)

(Dollars in thousands)

	Postretirement benefits	
	2013	**2012**
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent assets	$ —	—
Current liabilities	—	—
Noncurrent liabilities	(4,582)	(7,039)
Accumulated charge to unrestricted net assets	4,608	2,469
	$ 26	(4,570)

Amounts recognized as an accumulated credit to unrestricted net assets consist of the following:

	2013	**2012**
Net actuarial gain	$ 4,608	2,469

Net periodic benefic cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2013 and 2012 were as follows:

	Postretirement benefits	
	2013	**2012**
Net periodic benefit cost:		
Interest cost	$ 163	299
Amortization of net gain	(416)	(262)
Net periodic benefit cost recognized	(253)	37
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	(2,554)	(975)
Amortization of net gain	416	262
Total recognized in unrestricted net assets	(2,138)	(713)
Total recognized in net periodic benefit cost and unrestricted net assets	$ (2,391)	(676)

(Continued)

(Dollars in thousands)

The net gain and prior service credit for the defined-benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $(405) and $(168), respectively. Weighted average assumptions used to determine benefit obligations for 2013 and 2012 were as follows:

	2013	2012
Discount rate	4.00%	3.50%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2013 and 2012 were as follows:

	Postretirement benefits	
	2013	2012
Discount rate	3.50%	5.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 6.50% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2013.

The following table summarizes the effect of one-percentage-point increase/decrease in healthcare costs trends:

		2013	2012
Effect of one-percentage-point increase in healthcare cost trend on:			
Service and interest cost	$	10	21
Accumulated pension benefit obligation		271	533
Effect of one-percentage-point decrease in healthcare cost trend on:			
Service and interest cost	$	(9)	(19)
Accumulated pension benefit obligation		(242)	(473)

(Continued)

(Dollars in thousands)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2013 and 2012, respectively, were as follows:

	Fair value measurement at June 30, 2013 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 32,750	32,750	—	—
Cash and money market funds	543	543	—	—
Alternative funds	7,064	—	3,674	3,390
Total	$ 40,357	33,293	3,674	3,390

	Fair value measurement at June 30, 2012 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 29,223	29,223	—	—
Cash and money market funds	578	578	—	—
Alternative funds	6,990	—	3,443	3,547
Total	$ 36,791	29,801	3,443	3,547

(Continued)

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2013 and 2013:

	Alternative investments
Balance at June 30, 2011	$ 3,588
Net change in value	(29)
Purchases, issuances, and settlements	(12)
Transfers into and/or out of Level 3 (net)	—
Balance at June 30, 2012	3,547
Net change in value	(61)
Purchases, issuances, and settlements	(96)
Transfers into and/or out of Level 3 (net)	—
Balance at June 30, 2013	$ 3,390

There were no transfers between any levels during the years ended June 30, 2013 and 2012.

(14) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers' compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont had established revocable self-insurance trust funds to provide for professional and general liability claims and workers' compensation claims and related expenses. Wellmont's contributions to the self-insurance trusts were based upon actuarial determinations by an independent service company. The trust fund requirement for professional and general liability was eliminated in 2013. The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Workers' compensation expense under these programs amounted to approximately $3,681 and $4,100 for the years ended June 30, 2013 and 2012, respectively, and are included in salaries and benefits expense in the accompanying consolidated statements of operations and changes in net assets. All other self-insurance expense under these programs amounted to approximately $2,229 and $2,763 for the years ended June 30, 2013 and 2012, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2013 and 2012, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2013 that may result in the assertion of additional claims, and other claims

(Dollars in thousands)

may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2013 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

Wellmont is also self-insured for medical and other healthcare benefits provided to its employees and their families. A provision for estimated incurred but not reported claims has been provided in the consolidated financial statements.

(15) Commitments and Contingencies

Construction in progress at June 30, 2013 and 2012 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately $15,403 at June 30, 2013. Wellmont has entered into contracts of $15,403 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was $18,240 and $19,269 for the years ended June 30, 2013 and 2012, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2013 are as follows:

2014	$	9,076
2015		8,164
2016		5,749
2017		4,898
2018		4,377
Thereafter		15,251
	$	47,515

Wellmont has entered into contractual employment relationships with physicians to provide services to Wellmont physician practices that are intended to qualify under the employee safe harbor of the Anti-Kickback Statute and the employee exception of the Physician Self-Referral Law. These contracts have terms of varying lengths, guarantee certain base payments, and may provide for additional incentives based upon productivity.

(Dollars in thousands)

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, such matters as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes Wellmont is in compliance with fraud and abuse statutes and other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

(16) Functional Expense Disclosure

Wellmont provides healthcare services to residents within its geographic location. Expenses based upon functional classification related to providing these services during the years ended June 30 are as follows:

	2013	2012
Professional care of patients	$ 655,152	612,639
Administrative and general	128,955	152,171
Fund-raising	1,172	1,106
	$ 785,279	765,916

(17) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate-company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately $107,000 at June 30, 2013, which begin expiring in fiscal 2018 and expire through 2032. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately $1,780 for unrelated business activities. Management believes that it is more likely than not that deferred tax assets arising from net operating loss carryforwards will not be realizable. Accordingly, these are fully reserved at June 30, 2013 and 2012.

(Continued)

(Dollars in thousands)

(18) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2013 and 2012 was as follows:

	2013	2012
Medicare	53%	50%
TennCare	6	5
Medicaid	9	7
Other third-party payors	26	31
Patients	6	7
	100%	100%

(19) Disclosures about Fair Value of Financial Instruments

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer or settle a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820, *Fair Value Measurements and Disclosures*, establishes a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The classification of an investment within the hierarchy is based upon the pricing transparency or ability to redeem the investment and does not necessarily correspond to the perceived risk of that investment. Inputs are used in applying various valuation techniques that are assumptions, which market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, operating statistics, specific and broad credit data, liquidity statistics, recent transactions, earnings forecasts, future cash flows, market multiples, discount rates and other factors.

Assets and liabilities measured and reported at fair value are classified within the fair value hierarchy as follows:

Level 1 – Valuations based on quoted market prices in active markets.

Level 2 – Investments that trade in markets that are considered to be active, but are based on dealer quotations or alternative pricing sources supported by observable inputs or investments that trade in markets that are not considered to be active, but are valued based on quoted market prices, dealer quotations or alternative pricing sources supported by observable inputs.

Level 3 – Investments classified within Level 3 have significant unobservable inputs, as they trade infrequently or not at all.

(Dollars in thousands)

The level in the fair value hierarchy within which a fair measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2013:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 55,958	—	—	55,958
Assets limited as to use:				
Stock mutual funds	109,356	—	—	109,356
Bond mutual funds	175,594	—	—	175,594
Cash and money market funds	42,923	—	—	42,923
Real estate funds	16,377	—	—	16,377
Alternative investments	—	—	36,520	36,520
Subtotal	400,208	—	36,520	436,728
Long-term investments:				
Stock mutual funds	12,228	—	—	12,228
Bond mutual funds	13,478	—	—	13,478
Cash and money market funds	190	—	—	190
Real estate funds	1,220	—	—	1,220
Subtotal	27,116	—	—	27,116
	$ 427,324	—	36,520	463,844
Liabilities:				
Derivatives liability	$ —	7,425	—	7,425
Total	$ —	7,425	—	7,425

(Continued)

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2012:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 44,930	—	—	44,930
Assets limited as to use:				
Stock mutual funds	88,942	—	—	88,942
Bond mutual funds	163,401	—	—	163,401
Cash and money market funds	44,240	—	—	44,240
Real estate funds	7,157	—	—	7,157
Alternative investments	—	—	36,989	36,989
Corporate bonds	2,673	—	—	2,673
U.S. Treasury bonds	—	—	—	—
Subtotal	351,343	—	36,989	388,332
Long-term investments:				
Stock mutual funds	10,321	—	—	10,321
Bond mutual funds	13,926	—	—	13,926
Cash and money market funds	189	—	—	189
Real estate funds	685	—	—	685
Alternative investments	—	—	—	—
Subtotal	25,121	—	—	25,121
	$ 376,464	—	36,989	413,453
Liabilities:				
Derivatives liability	$ —	9,781	—	9,781
Total	$ —	9,781	—	9,781

The following methods and assumptions were used to estimate fair value of each class of instruments:

- *Cash and Cash Equivalents*

  The carrying amount approximates fair value due to the short maturities of these instruments.

- *Patient Accounts and Other Receivables*

  The net recorded carrying value approximates fair value due to the short maturities of these instruments.

(Continued)

- *Investments and Assets Limited as to Use*

  The fair values of investments and assets limited as to use are based on quoted market prices and quotes obtained from security brokers or, in the case of the limited partnerships, by the general partner.

  Wellmont also applies the measurement provisions of ASU No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was $36,520 and $36,989 at June 30, 2013 and 2012, respectively.

- *Accounts Payable and Accrued Expenses*

  The carrying amount approximates fair value due to the short maturities of these liabilities.

- *Estimated Third-Party Payor Settlements, Other Long-Term Liabilities*

  The carrying amount approximates fair market value due to the nature of these liabilities.

- *Long-Term Debt*

  The carrying amount of indebtedness with variable interest rates approximates its fair value because the variable rates reflect current market rates for indebtedness with similar maturities and credit quality. The fair value of indebtedness with fixed interest rates is based on rates assumed to be currently available for indebtedness with similar terms and average maturities. Fair value measurements of indebtedness are based on observable interest rates and maturity schedules that fall within Level 2 of the hierarchy of fair value inputs. The estimated fair value of revenue bonds, using current market rates, was estimated at $436,832 and $436,634 for the years ended June 30, 2013 and 2012, respectively. The carrying amount of other long-term debt reported in Note 11 and on the consolidated balance sheet approximates the related fair value.

(Dollars in thousands)

The following table presents additional information about Level 3 assets measured at fair value. Both observable and unobservable inputs may be used to determine the fair value of positions that the Health System has classified within the Level 3 category. As a result, the unrealized gains and losses for assets within the Level 3 category in the table below may include changes in fair value that were attributable to both observable and unobservable inputs.

		Alternative investments
Balance at June 30, 2011	$	37,778
Total realized and unrealized gains (losses):		
Included in revenues and gains in excess of expenses and losses		264
Included in changes in net assets		(420)
Purchases, issuances, and settlements		(633)
Transfers into and/or out of Level 3 (net)		—
Balance at June 30, 2012		36,989
Total realized and unrealized gains (losses):		
Included in revenues and gains in excess of expenses and losses		(69)
Included in changes in net assets		1,113
Purchases, issuances, and settlements		(1,513)
Transfers into and/or out of Level 3 (net)		—
Balance at June 30, 2013	$	36,520

There were no transfers between any of the levels during the years ended June 30, 2013 and 2012.

(20) Subsequent Events

Effective October 1, 2013, Wellmont closed Lee Regional Medical Center in Pennington Gap, Virginia.

Wellmont has evaluated subsequent events from the balance sheet date through October 23, 2013, the date at which the consolidated financial statements were issued. No other material subsequent events were identified for recognition.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

Table of Contents

KPMG LLP
Suite 1000
401 Commerce Street
Nashville, TN 37219-2422

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Wellmont Health System and affiliates, which comprise the consolidated balance sheets as of June 30, 2014 and 2013, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Wellmont Health System and affiliates as of June 30, 2014 and 2013, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Nashville, Tennessee
October 24, 2014

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2014 and 2013

(Dollars in thousands)

Assets		2014	2013
Current assets:			
Cash and cash equivalents	$	30,674	55,958
Assets limited as to use, required for current liabilities		3,233	5,061
Patient accounts receivable, less allowance for uncollectible accounts of approximately $38,007 and $25,991 in 2014 and 2013, respectively		117,265	107,029
Other receivables		14,685	17,995
Inventories		18,684	18,361
Prepaid expenses and other current assets		10,337	8,949
Total current assets		194,878	213,353
Assets limited as to use, net of current portion		425,740	375,709
Land, buildings, and equipment, net		492,581	474,730
Other assets:			
Long-term investments		32,521	28,628
Investments in affiliates		18,221	31,874
Deferred debt expense, net		4,226	5,178
Goodwill		51,649	15,096
Other		520	547
		107,137	81,323
Total assets	$	1,220,336	1,145,115
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	18,015	15,002
Accounts payable and accrued expenses		90,547	84,300
Estimated third-party payor settlements		8,425	7,157
Current portion of other long-term liabilities		6,510	6,198
Other current liabilities		11,700	—
Total current liabilities		135,197	112,657
Long-term debt, less current portion		490,443	475,946
Other long-term liabilities, less current portion		43,866	41,567
Total liabilities		669,506	630,170
Net assets:			
Unrestricted		538,607	503,934
Temporarily restricted		8,214	6,927
Permanently restricted		1,319	1,311
Total net assets attributable to Wellmont		548,140	512,172
Noncontrolling interests		2,690	2,773
Total net assets		550,830	514,945
Commitments and contingencies			
Total liabilities and net assets	$	1,220,336	1,145,115

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2014 and 2013

(Dollars in thousands)

	2014	2013
Revenue:		
Patient service revenue	$ 788,910	791,230
Provision for bad debt	(45,644)	(53,251)
Net patient revenue less provision for bad debt	743,266	737,979
Other revenues	29,441	42,127
Total revenue	772,707	780,106
Expenses:		
Salaries and benefits	374,309	373,150
Medical supplies and drugs	166,676	162,604
Purchased services	73,674	77,716
Interest	18,350	20,292
Depreciation and amortization	50,058	49,465
Maintenance and utilities	36,978	36,830
Lease and rental	15,506	17,892
Other	32,312	26,745
Total expenses	767,863	764,694
Income from operations	4,844	15,412
Nonoperating gains:		
Investment income	14,749	19,316
Derivative valuation adjustments	1,307	2,356
Loss on refinancing	(1,133)	—
Gain on revaluation of equity method investment	14,744	—
Nonoperating gains, net	29,667	21,672
Revenue and gains in excess of expenses and losses before discontinued operations	34,511	37,084
Discontinued operations	(26,639)	(4,484)
Revenue and gains in excess of expenses and losses	7,872	32,600
Income attributable to noncontrolling interests	(1,540)	(1,228)
Revenues and gains in excess of expenses and losses attributable to Wellmont	6,332	31,372
Other changes in unrestricted net assets:		
Change in net unrealized gains (losses) on investments	28,333	6,157
Net assets released from restrictions for additions to land, buildings, and equipment	901	828
Change in the funded status of benefit plans and other	(893)	7,359
Increase in unrestricted net assets	34,673	45,716
Changes in temporarily restricted net assets:		
Contributions	2,707	2,977
Net assets released from temporary restrictions	(1,420)	(1,789)
Increase in temporarily restricted net assets	1,287	1,188
Changes in permanently restricted net assets – investment income	8	7
Changes in noncontrolling interests:		
Income attributable to noncontrolling interests	1,540	1,228
Distributions to noncontrolling interests	(1,623)	(1,220)
Change in noncontrolling interests	(83)	8
Change in net assets	35,885	46,919
Net assets, beginning of year	514,945	468,026
Net assets, end of year	$ 550,830	514,945

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2014 and 2013

(Dollars in thousands)

	2014	2013
Cash flows from operating activities:		
Change in net assets	$ 35,885	46,919
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	50,526	51,392
(Gain) loss on disposal of land, buildings, and equipment	(78)	211
Equity in earnings of affiliated organizations	(1,764)	(4,594)
Distributions from affiliated organizations	3,484	5,366
Amortization of deferred financing costs	426	486
Net realized and unrealized gain on investments	(31,302)	(9,580)
Provision for bad debts	40,237	55,029
Change in fair value of derivative instruments	(1,307)	(2,356)
Loss on refinancing	1,133	—
Gain on revaluation of equity method investment	(14,744)	—
Loss on impairment	22,456	2,007
Changes in assets and liabilities, net of acquisitions:		
Patient accounts receivable	(44,839)	(53,793)
Other current assets	(1,711)	(1,986)
Other assets	3,297	5,872
Accounts payable and accrued expenses	5,474	(2,532)
Estimated third-party payor settlements	1,268	(8,378)
Other current liabilities	11,358	416
Other liabilities	2,998	(10,137)
Net cash provided by operating activities	82,797	74,342
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	123,193	115,439
Purchase of investments	(141,095)	(135,222)
Purchase of land, buildings, and equipment	(86,879)	(57,747)
Proceeds from the sale of buildings and equipment	2,434	355
Cash paid for acquisitions	(22,637)	(13)
Net cash used in investing activities	(124,984)	(77,188)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	128,623	28,908
Payments on long-term debt	(111,092)	(14,789)
Payment of debt issuance costs	(628)	(245)
Net cash provided by financing activities	16,903	13,874
Net (decrease) increase in cash and cash equivalents	(25,284)	11,028
Cash and cash equivalents, beginning of year	55,958	44,930
Cash and cash equivalents, end of year	$ 30,674	55,958

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of $1,345 and $5,262 in 2014 and 2013, respectively.

Additions to property and equipment financed through current liabilities of $3,770 and $5,589 in 2014 and 2013, respectively.

See accompanying notes to consolidated financial statements.

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont), a Tennessee not-for-profit corporation, currently operates six acute care hospitals in Tennessee and Virginia that include Bristol Regional Medical Center in Bristol, Tennessee, Holston Valley Medical Center in Kingsport, Tennessee, Lonesome Pine Hospital in Big Stone Gap, Virginia, Hawkins County Memorial Hospital in Rogersville, Tennessee, Hancock County Hospital in Sneedville, Tennessee, and Mountain View Regional Medical Center in Norton, Virginia.

The consolidated financial statements also include the operations of:

- Wellmont Cardiology Services and Wellmont Medical Associates, which operate physician practices.
- Wellmont Madison House and Wellmont Wexford House, which operate assisted living, adult day care, and skilled nursing facilities.
- Wellmont Foundation, which conducts fund-raising activities for the benefit of Wellmont.
- Wellmont Integrated Network, LLC, which is an accountable care organization.
- Wellmont Insurance Company SPC, Ltd, which is a captive insurance company.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection services, provide other healthcare-related services, and invest in affiliates and other activities.

All significant intercompany accounts and transactions have been eliminated in the accompanying consolidated financial statements.

Wellmont's continuing operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

The following are included in discontinued operations:

- As of October 1, 2013, Wellmont closed Lee Regional Medical Center in Pennington Gap, Virginia. The losses of $26,091 and $2,317, including an impairment loss of $22,456 and $0, for the years ended June 30, 2014 and 2013, respectively, are included in discontinued operations
- As of May 17, 2013, a subsidiary of Wellmont ceased operating its sleep labs, which were managed by a third party. The losses of $292 and $2,302, including an impairment loss of $0 and $2,007, for the years ended June 30, 2014 and 2013, respectively, are included in discontinued operations.
- As of September 23, 2010, Wellmont sold the majority of its retail pharmacy's assets to a national pharmacy company. The gains (losses) of $45 and ($131) for the years ended June 30, 2014 and 2013, respectively, are included in discontinued operations.
- As of April 30, 2009, Wellmont closed Jenkins Community Hospital in Jenkins, Kentucky. The gains (losses) of ($301) and $266 for the years ended June 30, 2014 and 2013, respectively, are included in discontinued operations.

(2) Significant Accounting Policies

A summary of significant accounting policies is as follows:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) 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. Significant estimates include allowances for contractual adjustments and bad debts; third-party payor settlements; valuation of investments, land, buildings, equipment, and goodwill; and self-insurance and other liabilities. Actual results could differ from these estimates.

(b) Cash and Cash Equivalents

Wellmont considers all highly liquid investments with a maturity of three months or less when purchased, excluding amounts whose use is limited by board of directors' designation or other arrangements under trust agreements, to be cash equivalents.

(c) Investments

Marketable equity securities and debt securities are recorded at fair value and classified as other than trading. Fair value is determined primarily using quoted prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date. However, Wellmont also uses observable and unobservable inputs for investments without quoted market prices to determine the fair value of certain investments at the measurement date. Investments in limited partnerships are recorded at fair value as determined by the partnership using net asset value. Wellmont has adopted the measurement provisions of Accounting Standards Update (ASU) No. 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. Investments in affiliates in which Wellmont has significant influence but does not control are reported on the equity method of accounting, which represents Wellmont's equity in the underlying net book value. Long-term investments include those investments that have not been designated by the board of directors for specific purposes and are also not intended to be used for the liquidation of current liabilities. Investment income is recognized when earned.

Realized gains and losses are determined on the specific-identification method and included in investment income with interest and dividends. Investment income is reported net of related investment fees. Unrealized gains and losses are included in other changes in unrestricted net assets except for losses determined to be other than temporary, which are considered realized losses and included in investment income.

(Continued)

(d) Assets Limited as to Use

Assets limited as to use primarily include designated assets set aside by the board of directors for future capital improvements, over which the board of directors retains control and may, at its discretion, subsequently use for other purposes, and assets held by trustees under bond indenture and self-insurance arrangements. Amounts required to meet current liabilities of Wellmont have been reclassified to current assets in the accompanying consolidated balance sheets.

(e) Inventories

Inventories are stated at the lower of cost or market value and are valued principally by the first-in, first-out, and average-cost methods.

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, if purchased, or fair value at date of donation. Depreciation is computed using the straight-line method based on the estimated useful life of the asset, ranging from 3 to 40 years. Buildings and equipment held under capital leases are recorded at net present value of future lease payments and are amortized on a straight-line basis over the shorter of the lease term or estimated useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Upon sale or retirement of land, buildings, or equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss, if any, is included in other revenues on the consolidated statements of operations and changes in net assets. 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.

Wellmont evaluates long-lived assets for impairment on annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset.

(g) Goodwill

Wellmont adopted ASU No. 2010-07, *Not for Profit Entities: Mergers and Acquisitions*, which in part requires healthcare entities to follow Accounting Standards Codification (ASC) Topic 350-20-35, *Intangibles – Goodwill and Other* along with ASU 2011-08, *Testing Goodwill for Impairment*, effective July 1, 2012. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. An entity has the option to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its

carrying amount. If, after assessing the totality of events or circumstances, an entity determines it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. The more-likely than-not threshold is defined as having a likelihood of more than 50%. However, if an entity concludes otherwise, then it is required to perform the first step of the two-step impairment test by calculating the fair value of the reporting unit and comparing the fair value with the carrying amount (including goodwill) of the reporting unit. If the carrying amount of a reporting unit exceeds its fair value, then the entity is required to perform the second step of the goodwill impairment test to measure the amount of the impairment loss. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. The annual impairment test is performed as of June 30.

(h) Deferred Debt Expense

Deferred debt expense is amortized over the life of the related bond issues using the effective-interest method.

(i) Derivative Financial Instruments

As further described in note 12, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) Asset Retirement Obligations

Asset retirement obligations (AROs) are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value, and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, Wellmont records period-to-period changes in the ARO liability resulting from the passage of time and revisions to either the timing or the amount of the original estimate of undiscounted cash flows. Wellmont derecognizes ARO liabilities when the related obligations are settled.

(k) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by Wellmont has been limited by donors to a specific-time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by Wellmont in perpetuity. Generally, donors of permanently restricted assets permit use of all or part of the income earned on related investments for general or specific purposes.

Temporarily restricted net assets relate primarily to amounts held by the Foundation and include amounts restricted for future capital expenditures and for operations of such areas as children's healthcare services, hospice, and cancer care.

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2014 and 2013 primarily included amounts related to the purchase of equipment for pediatrics, cancer, and other healthcare operations.

Wellmont has adopted guidance issued by Financial Accounting Standards Board (FASB), which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA). Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of five individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the

period related services are rendered and adjusted in future periods as final and other settlements are determined. On the basis of historical experience, a significant portion of Wellmont's uninsured patients will be unable or unwilling to pay for the services provided. Therefore, Wellmont records a significant provision for bad debts related to uninsured patients in the period the services are provided. This provision for bad debts is presented on the statements of operations as a component of net patient revenue. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

Patient accounts receivable are reported net of both an allowance for contractual adjustments and an allowance for uncollectible accounts. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, TennCare, Medicaid, and other third-party payment programs. Wellmont's policy does not require collateral or other security for patient accounts receivable. Wellmont routinely obtains assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans, or policies.

(m) Revenue and Gains in Excess of Expenses and Losses

The consolidated statements of operations and changes in net assets include revenue and gains in excess of expenses and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include changes in net unrealized gains (losses) on investments other than trading securities, changes in the funded status of Wellmont's defined-benefit plan, contributions of long-lived assets, including assets acquired using contributions that, by donor restriction, were to be used for the purposes of acquiring such assets, and cumulative effects of changes in accounting principles.

For purposes of financial statement display, those activities directly associated with Wellmont's mission of providing healthcare services are considered to be operating activities. Nonoperating activities primarily include investment and related activities. Other operating revenues primarily include cafeteria, rental, meaningful use incentives, and income from affiliates.

(n) Contributed Resources

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted contributions, and are excluded from revenue and gains in excess of expenses and losses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. Gifts are reported as either a temporarily or permanently restricted contribution if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished,

temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions. Unrestricted contributions are included in other revenues.

(o) Federal Income Taxes

The Wellmont entities are primarily classified as organizations exempt from federal income taxes under Section 501(a) as entities described in Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been included for these entities in the consolidated financial statements. The operations of Wellmont, Inc. are subject to state and federal income taxes, which are accounted for in accordance with ASC Topic 740, *Income Taxes*; however, such amounts are not material.

(p) Recently Adopted Accounting Standards

The FASB issued ASU No. 2011-04, *Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs*, in May 2011. This ASU requires the reason for the fair value measurement to be disclosed, a description of the valuation techniques, and descriptions of the inputs used for all Level 2 and Level 3 fair value measurements. It also requires all transfers between levels of the fair value hierarchy to be separately reported and described. Wellmont adopted ASU 2011-04 as of July 1, 2012.

(q) Reclassifications

Certain 2013 amounts have been reclassified to conform to the 2014 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

(3) Business Combinations and Goodwill

On November 30, 2013, Wellmont purchased 100% of the membership interest in Wexford House from Residential Healthcare Affiliates. Wexford House is a skilled nursing facility, which serves residents of Sullivan County, Tennessee and the surrounding communities. The facility provides short- and long-term medical and rehabilitation care. In addition, on March 31, 2014, Wellmont purchased the remaining 25% interest in Holston Valley Imaging Center (HVIC), which included the remaining 50% governance interest from Blue Ridge Radiology Investment. The assets acquired and liabilities assumed under each acquisition were recorded at their estimated fair value in accordance with ASC 805.

(Dollars in thousands)

The following table summarizes the consideration paid and the estimated fair value of the assets acquired and liabilities assumed at the business combination date:

		Wexford	HVIC
Consideration:			
Cash	$	14,770	7,867
Fair value of Wellmont's equity interest in HVIC held before acquisition		—	23,601
	$	14,770	31,468
Recognized amounts of identifiable assets acquired and liabilities assumed:			
Current assets	$	2,976	2,474
Other assets		5,277	241
Current liabilities		(564)	(863)
Long-term liabilities		(608)	—
Total identifiable net assets		7,081	1,852
Goodwill		7,689	29,616
	$	14,770	31,468

Wellmont recognized a gain of $14,744 as a result of remeasuring to fair value its 75% equity interest in HVIC held before the business combination. The gain is included in nonoperating gains (losses) on the consolidated statement of operations for the year ended June 30, 2014.

A summary of goodwill for the years ended June 30 is as follows:

		2013	Additions	Decreases	2014
Goodwill	$	15,096	37,305	(752)	51,649

		2012	Additions	Decreases	2013
Goodwill	$	17,090	13	(2,007)	15,096

(Continued)

(Dollars in thousands)

(4) 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 consolidated statements of operations and changes in net assets is as follows for the years ended June 30:

		2014	2013
Gross patient service revenue	$	2,683,891	2,452,561
Less:			
Contractual adjustments and other discounts		(1,838,900)	(1,605,045)
Charity care		(56,081)	(56,286)
Net patient service revenue before provision for bad debts		788,910	791,230
Less provision for bad debts		(45,644)	(53,251)
Net patient service revenue	$	743,266	737,979

Wellmont's allowance for doubtful accounts is predominantly for self-pay patients and patient balances remaining after third-party payments. The provision for bad debts decreased $7,607 from fiscal 2013 to fiscal 2014 and the net write-offs decreased $19,262 from fiscal 2013 to fiscal 2014. The decrease in the provision for bad debts was primarily offset by an increase of $6,594 in self-pay discounts. The decrease in write-offs was due to the above item and the implementation of a new billing system in the last quarter of the fiscal year. Wellmont has not changed its charity care or uninsured discount policies during fiscal 2014. Wellmont does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(5) Third-Party Reimbursement Arrangements

Wellmont renders services to patients under contractual arrangements with the Medicare and Medicaid programs. The Medicaid programs in Tennessee and Virginia are contracted by each state to commercial managed care contractors to cover Medicaid eligible enrollees. Amounts earned under these contractual arrangements are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Management believes that adequate provision has been made for any adjustments that may result from such reviews. Participation in these programs subjects Wellmont to significant rules and regulations; failure to adhere to such could result in fines, penalties, or expulsion from the programs.

Wellmont contracts with various managed care organizations under the Medicaid programs. Reimbursement for both inpatient and outpatient services is based upon prospectively determined rates, including diagnostic-related group assignments, fee schedules, and per diem amounts. Reimbursement under the Medicaid program is also based upon prospectively determined amounts.

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and

(Dollars in thousands)

medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid-eligible and other low-income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

Net patient service revenue in 2014 and 2013 related to Medicare and TennCare/Medicaid and net patient accounts receivable at June 30, 2014 and 2013 from Medicare and TennCare/Medicaid were as follows:

		2014	2013
Net patient service revenue:			
Medicare	$	304,713	313,429
TennCare/Medicaid		37,216	39,515
Net patient accounts receivable:			
Medicare	$	44,480	38,102
TennCare/Medicaid		6,817	6,146

Wellmont has filed cost reports with Medicare and Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2010 and audit adjustments have been received and considered for certain hospitals and year-ends through June 30, 2012.

Wellmont has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, per diem rates, and discounts from established charges.

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately $3,334 and $6,605 in 2014 and 2013, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2014 could differ materially from actual settlements based on the results of third-party audits.

(6) Meaningful Use Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record (EHR) technology. The Medicare incentive payments are paid out to qualifying hospitals and physician groups over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals, and physician groups must meet EHR "meaningful use" criteria that

become more stringent over three stages as determined by Centers for Medicare & Medicaid Services (CMS). Medicaid programs and payment schedules vary from state to state.

For fiscal years ended June 30, 2014 and 2013, Wellmont recorded $7,211 and $12,267, respectively, in other operating revenue related to the EHR and meaningful use incentives. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

Amounts recognized represent management's best estimates for payments ultimately expected to be received based on estimated discharges, charity care, and other input data. Subsequent changes to these estimates will be recognized in other operating revenue in the period in which additional information is available. Such estimates are subject to audit by the federal government or its designee.

(7) Charity Care and Community Services

Wellmont accepts all patients within its primary service area regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies that consider, among other factors, generally recognized poverty income levels.

Wellmont maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone and estimated costs incurred for services and supplies furnished under its charity care policy. Costs incurred are estimated based on the ratio of total operating expenses to gross charges applied to charity care charges. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were $56,081, $14,567, and 2.39%, respectively, for the year ended June 30, 2014 and $56,286, $15,735, and 2.57%, respectively, for the year ended June 30, 2013.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and state indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled $37,432 and $45,056 for the years ended June 30, 2014 and 2013, respectively.

Wellmont also provides services to the community at large for which it receives little or no payment. Health evaluations, screening programs, and specific services for the elderly and homebound are other services supplied. Wellmont also provides public health education, trains new health professionals, and conducts health research.

(8) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include hospital, home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately $1,764 and $4,594 for the years ended June 30, 2014 and 2013, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont received distributions of $3,484 and $5,366 during 2014 and 2013, respectively, which reduced Wellmont's overall investment in the affiliates.

(Dollars in thousands)

The following table summarizes the unaudited aggregate financial information of Wellmont's investments in affiliates:

		2014	2013
Total assets	$	136,824	135,802
Total liabilities		38,396	40,617
Total net assets	$	98,428	95,185
Net revenues	$	201,639	200,765
Expenses		191,023	186,394
Revenues in excess of expenses	$	10,616	14,371

Wellmont's investment in these affiliates and its ownership percentage as of June 30, 2014 and 2013 is as follows:

		Amount		Percentages	
		2014	2013	2014	2013
Takoma Regional Hospital	$	10,763	11,983	60%	60%
Holston Valley Imaging Center (HVIC)		—	8,336	—	75
Advanced Home Care (AHO)		6,092	6,092	6	6
Lab Group Holdings, LLC		—	3,500	—	1
Others		1,366	1,963	25%–50%	25%–50%
	$	18,221	31,874		

As of March 31, 2014, Wellmont purchased the remaining 25% interest in HVIC and included HVIC in the consolidated financial statements from that date.

Prior to this transaction and although Wellmont's ownership percentage in Takoma Regional Hospital and HVIC was greater than 50%, Wellmont did not consolidate these entities because Wellmont only had a 50% representation on each respective board and did not have control over these entities. Also, during the fiscal year ended June 30, 2014, Lab Group Holdings, LLC was purchased by another entity, which also purchased all of Wellmont's share in this entity.

Wellmont provided billing, management, and professional services to some of the affiliates. Income recognized by Wellmont for the services was $173 in 2014 and $971 in 2013 and is included in other revenues. Included in other receivables are $242 and $406 as of June 30, 2014 and 2013, respectively, of amounts due to Wellmont from these entities.

(Continued)

(Dollars in thousands)

(9) Investments

Long-term investments, including assets limited as to use, at June 30 are reported at fair value and consist of the following:

	2014	2013
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	$ 148,453	109,356
Bond mutual funds	167,156	175,594
Cash and money market funds	5,904	3,749
Real estate funds	21,381	16,377
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	14,215	10,504
Illiquid	26,852	26,016
	383,961	341,596
Assets limited as to use under self-insurance agreements:		
Cash and money market funds	16,051	—
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	28,961	39,174
Less assets limited as to use that are required for current liabilities	3,233	5,061
Assets limited as to use, net of current portion	$ 425,740	375,709
Long-term investments:		
Stock mutual funds	$ 17,741	12,228
Bond mutual funds	11,420	13,478
Preferred equity investment and related options	1,512	1,512
Cash, money market funds, and certificates of deposit	230	190
Real estate funds	1,618	1,220
Total long-term investments	$ 32,521	28,628

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately $10,162 as of June 30, 2014 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which $567 was paid subsequent to June 30, 2014.

Effective June 27, 2013, Wellmont redeemed its $10,000 in the preferred equity of a regional managed services organization; however, retained its $1,512 on a right of first refusal related to any future sale of this organization. This equity had a guaranteed annual return of at least 6.5% of the outstanding preferred equity balance.

Wellmont's investments are concentrated in stock and bond mutual funds. In the event of a downward trend in the stock and bond markets, Wellmont's overall market value of net assets could be adversely

(Dollars in thousands)

affected by a material amount. Investments in alternative investments are generally illiquid investments whose value is determined by the general partner such as hedge funds, private equity, commingled funds, and real estate funds. Distributions are only at the discretion of a voting majority of the general partners.

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, Wellmont recognized other-than-temporary impairment losses of $0 and $131 on investments as of June 30, 2014 and 2013, respectively. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2014 and 2013 were as follows:

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2014:						
Alternative investments	$ —	—	647	878	647	878
Mutual funds	16	1,655	3,632	119,716	3,648	121,371
	$ 16	1,655	4,279	120,594	4,295	122,249

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2013:						
Alternative investments	$ 478	3,243	—	—	478	3,243
Mutual funds	7,304	181,780	371	3,185	7,675	184,965
	$ 7,782	185,023	371	3,185	8,153	188,208

Investment income is comprised of the following for the years ended June 30:

	2014	2013
Interest and dividends, net of amounts capitalized	$ 11,780	15,893
Realized gains on investments, net	2,969	3,423
Investment income, net	$ 14,749	19,316
Change in net unrealized gains on investment	$ 28,333	6,157

(Continued)

(Dollars in thousands)

(10) Land, Buildings, and Equipment

Land, buildings, and equipment at June 30 consist of the following:

	2014	2013
Land	$ 49,825	49,758
Buildings and improvements	523,069	536,758
Equipment	490,805	384,747
Buildings and equipment under capital lease obligations	46,031	45,102
	1,109,730	1,016,365
Less accumulated depreciation	(623,930)	(576,210)
	485,800	440,155
Construction in progress	6,781	34,575
Land, buildings, and equipment	$ 492,581	474,730

Depreciation expense for the years ended June 30, 2014 and 2013 was $50,058 and $49,465, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was $21,789 and $18,408 as of June 30, 2014 and 2013, respectively.

(11) Other Long-Term Liabilities

Other long-term liabilities at June 30 consist of the following:

	2014	2013
Workers' compensation liability	$ 11,096	9,882
Professional and general liability	15,940	11,492
Postretirement benefit obligation	2,633	4,582
Asset retirement obligation	3,139	2,969
Deferred gain on sale of assets	409	439
Derivative liability	6,118	7,425
Pension benefit liability	11,041	10,393
Other	—	583
	50,376	47,765
Less current portion	(6,510)	(6,198)
Total other long-term liabilities	$ 43,866	41,567

(Continued)

(Dollars in thousands)

(12) Debt

(a) Long-Term Debt

Long-term debt consists of the following at June 30:

	2014	2013
Hospital Refunding Bonds, Series 2014A	$ 14,242	—
Hospital Refunding Bonds, Series 2014B	52,275	—
Hospital Refunding Bonds, Series 2014C	20,836	—
Hospital Revenue Bonds, Series 2014D	13,575	—
Hospital Revenue Refunding Bonds, Series 2011	75,300	76,165
Hospital Revenue Bonds, Series 2010 (Bank Qualified)	—	22,836
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	200,000	200,000
Hospital Revenue Refunding Bonds, Series 2005	—	54,820
Hospital Revenue Bonds, Series 2003	—	25,225
Project Odyssey 2012 Tax-Exempt Master Lease/Sublease Financing	40,589	16,150
Notes payable	10,232	11,968
Capital lease obligations	19,749	21,601
Other	674	847
	502,472	484,612
Unamortized premium	5,986	6,679
Unamortized discount	—	(343)
	508,458	490,948
Less current maturities	(18,015)	(15,002)
	$ 490,443	475,946

(b) Series 2014 Bonds

On June 25, 2014, Wellmont (a) refunded the Revenue Bonds, Series 2003, the Revenue Refunding Bonds, Series 2005, and the Revenue Bonds, Series 2010 (Bank Qualified), with the proceeds of the Hospital Revenue Refunding Bonds, Series 2014A, Series 2014B, and Series 2014C and (b) issued Series 2014D. The Series 2014A through Series 2014D Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2003, the Revenue Refunding Bonds, Series 2005, and the Revenue Bonds, Series 2010 (Bank Qualified) and to issue new debt in the amount of $13,575 to reimburse Wellmont for the purchase price of Wellmont Wexford House and to pay closing costs of issuing the Series 2014D Bonds. All of the Series 2014 Bonds were issued as tax-exempt and were issued in accordance with the Master Trust Indenture dated May 1, 1991.

(Continued)

The Series 2014 Bonds were issued with four maturities; Series 2014A for $14,242, maturing September, 1, 2019, Series 2014B for $52,275, maturing September 1, 2032, Series 2014C for $20,836, maturing September 1, 2024, and Series 2014D for $13,575, maturing September 1, 2040. Principal and interest will be paid annually, except there will be interest only paid on the Series 2014D through September 2030. Principal payments will begin on September 1, 2031.

Interest on the Series 2014 Bonds is 100% of LIBOR plus a quotient of applicable spread divided by 67%. Accrued interest is paid monthly in arrears. Interest rates on the 2014A, 2014B, 2014C, and 2014D Bonds were 0.92%, 1.02%, 0.85%, and 0.85%, respectively, as of June 30, 2014.

The Series 2014C and Series 2014D Bonds can be called by the bondholders June 1, 2021 and each successive year after that until they mature.

(c) Project Odyssey 2012 Tax-Exempt Master Lease/Sublease Financing

On December 1, 2012, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (as Lessee) and Wellmont (as Sub-Lessee) entered into a Master Equipment Lease and Sublease Agreement with Banc of America Public Capital Corp (the Lessor). The proceeds of this Master Lease were used to finance an electronic medical records system consisting of an EpicCare Inpatient Clinical System and an EpicCare Ambulatory Electronic Medical Records System inclusive of hardware, software, and implementation services. The Sub-Lessee authorized the Lessor to take a security interest in the entire System although only certain components of the System were funded under this Master Lease with the rest funded by Bank of America N.A. and Sub-Lessee. During the fiscal year ended June 30, 2013, Wellmont received two draws totaling $16,150. During the fiscal year ended June 30, 2014, Wellmont received two additional draws totaling $26,349.

Each lease term shall commence and interest shall begin to accrue on the date any funds are advanced by Wellmont. The first six lease payments under each agreement consist only of an interest component and the remaining 78 lease payments consist of a principal component and an interest component. Commencing on June 30, 2013, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Each agreement will have an interest component based on a fixed rate of interest and payable with respect to the amount of funds that the Lessor has advanced. The rates of interest are 1.79% and 1.97% for the two draws in the fiscal year ended June 30, 2014 and 1.45% and 1.82% for the two draws in the fiscal year ended June 30, 2013.

(d) Series 2011 Bonds

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

The Series 2011 Bonds were issued with two maturities of $42,385 and $33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2013 and ending on September 1, 2026 in annual amounts ranging from $865 to $4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from $4,980 to $6,300. The Series 2011 Bonds were issued as fixed-rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(e) Series 2010 Bank Qualified Bonds

On November 1, 2010, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (the Board) issued $30,000 Hospital Revenue Bonds, Series 2010 (Bank Qualified). The Series 2010 Bonds were issued and sold pursuant to the Bond Purchase Agreement dated as of November 1, 2010, between the Board and First Tennessee Bank National Association. Commencing on January 1, 2011, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Commencing on October 1, 2011 and continuing on the first day of each fiscal quarter thereafter, Wellmont shall also make principal payments equal to $500. The outstanding bonds accrue interest at a rate equal to the product of 65% of the sum of LIBOR plus the applicable margin; however, the Series 2010 Bonds were redeemed upon the issuance of the Series 2014C Bonds.

(f) Series 2007 Bonds

On July 24, 2007, The Virginia Small Business Financing Authority issued, on behalf of Wellmont, $55,000 of Hospital Revenue Bonds, Series 2007A. The Series 2007A Bonds, with other methods of financing, were used to purchase the assets of Mountain View Regional Medical Center and Lee Regional Medical Center.

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $360 to $2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of $29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.250%.

(g) Series 2006 C

On October 26, 2006, The Health, Educational, and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, $200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation, and equipping of an operating room and related facilities at Hawkins County Memorial Hospital.

Principal on outstanding Series 2006C Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,605 to $25,330 commencing on September 1, 2017 through September 1, 2036. The outstanding bonds accrue interest at rates ranging from 5.00% to 5.25%.

(h) Series 2005

On December 8, 2005, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $70,620 of Hospital Revenue Refunding Bonds, Series 2005. The Series 2005 Bonds together with other available funds were used to advance refund the previously issued Hospital Revenue Bonds, Series 2002, and to pay certain expenses incurred in connection with the issuance of the Series 2005 Bonds. Principal on outstanding Series 2005 Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,945 to $3,390 commencing on September 1, 2007 through September 1, 2032; however, the Series 2005 Bonds were redeemed upon the issuance of the Series 2014B Bonds.

(i) Series 2003

On June 1, 2003, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee, issued, on behalf of Wellmont, $59,100 of Hospital Revenue Bonds, Series 2003. The bonds were issued to provide funds necessary to refund Wellmont's Hospital Revenue Bonds, Series 1993 (HVHC), to fund a debt service reserve fund and to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds.

The Wellmont Series 2003 Bonds consist of $27,460 in fixed-rate serial bonds and $19,280 in fixed-rate term bonds payable through maturity or mandatory sinking fund redemption maturing in annual amounts ranging from $3,230 on September 1, 2007 to $4,140 on September 1, 2019; however, the Series 2003 Bonds were redeemed upon the issuance of the Series 2014A Bonds.

(j) Master Trust Indenture

The master trust indentures and loan agreements for the 2014, 2011, 2007, and 2006 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross

receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

Funds held by the trustee related to the various revenue bonds are available for specific purposes. The bond interest and revenue funds may be used only to pay interest and principal on the bonds; the debt service reserve fund may be used to pay interest and principal if sufficient funds are not available in the bond interest and revenue funds. The original issue discount and premium on all bond series outstanding are being amortized over the life of the bond issue using the effective-interest method.

(k) Notes Payable

During 2007, Wellmont entered into a five-year $3,000 note payable, which has a fixed interest rate of 7.25% and a termination date of July 2011. In August 2011, Wellmont renewed this note agreement in the amount of $1,760 with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate with a ceiling of 7.75% and a floor of 4.00% and a maturity date of August 2016. At June 30, 2014 and 2013, $828 and $1,199, respectively, were outstanding on this note.

During 2009, Wellmont entered into a five-year $2,400 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of October 2014. At June 30, 2014 and 2013, $150 and $379, respectively, were outstanding on this note.

On October 17, 2012, Wellmont entered into a 10-year $12,500 term note payable with Bank of America, N.A. The proceeds were used for the EpicCare system and its implementation, among other general corporate purposes. The note payable has a fixed interest rate of 3.27% and a maturity date of December 13, 2022. At June 30, 2014, $9,254 and $10,390 was outstanding on this note.

(l) Capital Lease Obligations

Assets under capital leases are included in property and equipment and have a net carrying value of $24,242 and $26,695 as of June 30, 2014 and 2013, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 2.1% to 12.0%.

(Dollars in thousands)

(m) Long-Term Debt Maturities Schedule

Bond maturities in accordance with the original terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2014 are as follows:

2015	$	18,015
2016		17,318
2017		16,405
2018		18,912
2019		19,638
Thereafter		412,184
	$	502,472

Interest paid for the years ended June 30, 2014 and 2013 was $18,899 and $19,622, respectively, net of amounts capitalized. Interest costs of $1,444 and $299 were capitalized in 2014 and 2013, respectively.

(13) Derivative Transactions

Wellmont is a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to postcollateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2014 and 2013, Wellmont was not required to postcollateral related to its swaps.

Market risk is the adverse effect on the value of a derivative instrument that results from a change in interest rates. The market risk associated with interest-rate contracts is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

(Dollars in thousands)

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2014 and 2013 of approximately $(6,118) and $(7,425), respectively, is included in other long-term liabilities in the consolidated balance sheets. The change in the fair value of the derivative instruments was approximately $1,307 and $2,356, respectively, in 2014 and 2013 and is included in nonoperating gains in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. The following is a summary of the interest rate swap information as of June 30, 2014:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2011	$ 75,300	May 5, 2011	September 1, 2032	1.410%	6.222%	$ 987
Pay fixed interest rate swap	*	52,275	December 13, 2005	September 1, 2016	3.548	0.101	(3,323)
Basis swap	*	56,465	September 1, 2002	September 1, 2032	0.060	0.173	(1,127)
Pay fixed interest rate swap	*	27,575	October 24, 2003	September 1, 2021	3.613	0.104	(2,655)
							$ (6,118)

* Previously designated bond series has been refinanced.

The following is a schedule detailing the swap information as of June 30, 2013:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2011	$ 76,165	May 5, 2011	September 1, 2032	1.400%	6.222%	$ 1,792
Pay fixed interest rate swap	Series 2005	54,820	December 13, 2005	September 1, 2016	3.548	0.082	(4,738)
Basis swap	*	58,680	September 1, 2002	September 1, 2032	0.050	0.163	(1,245)
Pay fixed interest rate swap	*	30,295	October 24, 2003	September 1, 2021	3.613	0.082	(3,234)
							$ (7,425)

* Previously designated bond series has been refinanced.

In September and October 2008, the counterparty and credit support provider, for four of the swaps held at that time, filed bankruptcy. The bankruptcy process is underway and the ultimate outcome regarding any final settlement cannot be determined at this time.

(14) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined-contribution retirement plan (Retirement Plan) that covers substantially all employees. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 2% (after October 1, 2013) and 3% (before October 1, 2013) of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which

cannot exceed certain limits established in the Internal Revenue Code, up to 2.4% (after October 1, 2013) and 3% (before October 1, 2013) of each participant's wages. The total pension expense related to the Retirement Plan was $10,687 and $12,765 for the years ended June 30, 2014 and 2013, respectively.

A predecessor to Wellmont sponsored a noncontributory, defined-benefit pension plan covering, substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. One of Wellmont's acquired hospitals also sponsored a defined-benefit pension plan covering substantially all its employees, but the two plans were merged on June 30, 2007 and effective June 30, 2010, the plan was frozen for all employees and no further benefits accrue.

The defined-pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. The funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined-benefit pension plans as an asset or liability in its consolidated balance sheet and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. The defined-benefit pension plans use a June 30 measurement date.

(Dollars in thousands)

The following table sets forth the funded status of the Plans, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		2014	2013
Change in benefit obligation:			
Benefit obligation at beginning of year	$	50,749	54,081
Service cost		—	—
Interest cost		2,196	2,102
Actuarial loss(gain)		5,815	(3,062)
Benefits paid		(2,469)	(2,372)
Benefit obligation at end of year		56,291	50,749
Change in plan assets:			
Fair value of plan assets at beginning of year		40,357	36,791
Actual return on plan assets		4,960	2,521
Employer contribution		2,402	3,417
Benefits paid		(2,469)	(2,372)
Fair value of plan assets at end of year		45,250	40,357
Funded status	$	(11,041)	(10,393)
Amounts recognized in the accompanying consolidated balance sheets:			
Pension benefit liability (other long-term liabilities)	$	(11,041)	(10,393)

(Continued)

(Dollars in thousands)

		2014	2013
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:			
Unrecognized actuarial loss	$	16,777	14,552
Unrecognized prior service cost		—	—
Net amounts included as an accumulated charge to unrestricted net assets	$	16,777	14,552
Calculation of change in unrestricted net assets:			
Accumulated charge to unrestricted net assets, end of year	$	16,777	14,552
Reversal of accumulated charge to unrestricted net assets, prior year		(14,552)	(19,773)
Change in unrestricted net assets	$	2,225	(5,221)
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Actuarial loss (gain) arising during the year	$	3,665	(3,003)
Amortization of actuarial loss		(1,440)	(2,218)
Amortization of prior service cost		—	—
Net amounts recognized in unrestricted net assets	$	2,225	(5,221)

(Continued)

(Dollars in thousands)

		2014	2013
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2013:			
Amortization of net loss	$	1,810	1,467
Amortization of prior service cost		—	—
Estimated future benefit payments:			
Fiscal 2014	$	—	2,590
Fiscal 2015		2,804	2,658
Fiscal 2016		2,894	2,741
Fiscal 2017		3,004	2,828
Fiscal 2018		3,093	2,907
Fiscal 2019–2023		19,937	15,736
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		4.00%	4.50%
Weighted average rate of increase in future compensation levels		N/A	N/A
Components of net periodic benefit cost (benefit):			
Service cost	$	—	—
Interest cost		2,196	2,102
Expected return on plan assets		(2,810)	(2,581)
Amortization of net loss		1,440	2,218
Net periodic benefit cost	$	826	1,739
Weighted average assumptions used to determine net periodic benefit cost:			
Settlement (discount) rate		4.50%	4.00%
Expected long-term return on plan assets (HVMC)		7.00	7.00
Expected long-term return on plan assets (LPH)		7.00	7.00
Weighted average rate of increase in future compensation levels		N/A	N/A

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont has developed a plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

(Continued)

(Dollars in thousands)

The table below shows the target allocation and actual asset allocations as of June 30, 2014 and 2013:

Asset	Target allocation	2014	2013
Equity securities	47%	48%	48%
Fixed income	41	33	33
Cash	—	3	1
Other	12	16	18

Wellmont monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

A predecessor to Wellmont also participates in a health and welfare plan for its retirees. The plan provides postretirement medical and life insurance benefits to certain employees who meet minimum age and service requirements. Effective January 1, 1995, the death benefit was changed to provide a flat $5 benefit to all future retirees. During 1995, the medical program for retirees was amended to terminate medical benefits for any active employees who would not meet the full eligibility requirements of the program by January 1, 1996. The plan is contributory and contains other cost-sharing features such as deductibles and coinsurance.

The following table sets forth the postretirement plan's funded status, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

	Postretirement benefits	
	2014	2013
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 4,582	7,039
Interest cost	96	163
Plan participants contributions	17	19
Actuarial losses	(1,978)	(2,554)
Benefits paid	(84)	(85)
Benefit obligation at end of year	2,633	4,582
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	66	66
Plan participants contributions	17	19
Benefits paid	(83)	(85)
Fair value of plan assets at end of year	—	—
Funded status	$ (2,633)	(4,582)

(Continued)

(Dollars in thousands)

	Postretirement benefits	
	2014	**2013**
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent assets	$ —	—
Current liabilities	—	—
Noncurrent liabilities	(2,633)	(4,582)
Accumulated charge to unrestricted net assets	5,939	4,608
	$ 3,306	26

Amounts recognized as an accumulated credit to unrestricted net assets consist of the following:

	2014	**2013**
Net actuarial gain	$ 5,939	4,608

Net periodic benefic cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2014 and 2013 were as follows:

	Postretirement benefits	
	2014	**2013**
Net periodic benefit cost:		
Interest cost	$ 95	163
Amortization of net gain	(646)	(416)
Net periodic benefit recognized	(551)	(253)
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	(1,978)	(2,554)
Amortization of net gain	646	416
Total recognized in unrestricted net assets	(1,332)	(2,138)
Total recognized in net periodic benefit cost and unrestricted net assets	$ (1,883)	(2,391)

(Continued)

(Dollars in thousands)

The net gain and prior service credit for the defined-benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $(646) and $(416), respectively. Weighted average assumptions used to determine benefit obligations for 2014 and 2013 were as follows:

	2014	2013
Discount rate	3.50%	4.00%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2014 and 2013 were as follows:

	Postretirement benefits	
	2014	2013
Discount rate	4.00%	4.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 6.7% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2014.

The following table summarizes the effect of one-percentage-point increase/decrease in healthcare costs trends:

		2014	2013
Effect of one-percentage-point increase in healthcare cost trend on:			
Service and interest cost	$	4	10
Accumulated pension benefit obligation		132	271
Effect of one-percentage-point decrease in healthcare cost trend on:			
Service and interest cost	$	(3)	(9)
Accumulated pension benefit obligation		(116)	(242)

(Continued)

(Dollars in thousands)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2014 and 2013, respectively, were as follows:

	Fair value measurement at June 30, 2014 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 36,546	36,546	—	—
Cash and money market funds	1,416	1,416	—	—
Alternative funds	7,425	—	3,935	3,490
Total	$ 45,387	37,962	3,935	3,490

	Fair value measurement at June 30, 2013 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 32,750	32,750	—	—
Cash and money market funds	543	543	—	—
Alternative funds	7,064	—	3,674	3,390
Total	$ 40,357	33,293	3,674	3,390

(Continued)

(Dollars in thousands)

The following table presents Wellmont's activity for assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820 for the years ended June 30, 2014 and 2013:

	Alternative investments
Balance at June 30, 2012	$ 3,547
Net change in value	(61)
Purchases, issuances, and settlements	(96)
Transfers into and/or out of Level 3 (net)	—
Balance at June 30, 2013	3,390
Net change in value	232
Purchases, issuances, and settlements	(132)
Transfers into and/or out of Level 3 (net)	—
Balance at June 30, 2014	$ 3,490

There were no transfers between any levels during the years ended June 30, 2014 and 2013.

(15) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers' compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont had established revocable self-insurance trust funds to provide for professional and general liability claims and workers' compensation claims and related expenses. Wellmont's contributions to the self-insurance trusts were based upon actuarial determinations by an independent service company. The trust fund requirement for professional and general liability was eliminated in fiscal year 2013.

Wellmont Insurance Company SPC, Ltd (the captive) was formed in 2014 as a wholly owned captive insurance company in the Cayman Islands. The captive holds Wellmont's self-insurance liabilities for professional and general liability and is funded by transfers from Wellmont Health System. These funds are included in assets limited as to use.

The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Workers' compensation expense under these programs amounted to approximately $3,695 and $3,588 for the years ended June 30, 2014 and 2013, respectively, and are included in salaries and benefits expense in the accompanying consolidated statements of operations and changes in net assets. All other self-insurance expense under these programs amounted to approximately $5,707 and $2,229 for the years ended June 30, 2014 and 2013, respectively,

(Dollars in thousands)

and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2014 and 2013, Wellmont was involved in litigation relating to medical malpractice and workers' compensation claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2014 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2014 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

Wellmont is also self-insured for medical and other healthcare benefits provided to its employees and their families. A provision for estimated incurred but not reported claims has been provided in the consolidated financial statements.

(16) Commitments and Contingencies

Construction in progress at June 30, 2014 and 2013 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately $24,685 at June 30, 2014. Wellmont has entered into contracts of $24,685 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was $15,506 and $17,892 for the years ended June 30, 2014 and 2013, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2014 are as follows:

2015	$	11,222
2016		8,117
2017		7,210
2018		6,439
2019		6,167
Thereafter		20,423
	$	59,578

Wellmont has entered into contractual employment relationships with physicians to provide services to Wellmont physician practices that are intended to qualify under the employee safe harbor of the Anti-Kickback Statute and the employee exception of the Physician Self-Referral Law. These contracts have terms of varying lengths, guarantee certain base payments, and may provide for additional incentives based upon productivity.

(Dollars in thousands)

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, such matters as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes Wellmont is in compliance with fraud and abuse statutes and other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

(17) Functional Expense Disclosure

Wellmont provides healthcare services to residents within its geographic location. Expenses based upon functional classification related to providing these services during the years ended June 30 are as follows:

		2014	2013
Professional care of patients	$	610,162	613,277
Administrative and general		156,647	150,245
Fund-raising		1,054	1,172
	$	767,863	764,694

(18) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate-company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately $111,000 at June 30, 2014, which begin expiring in fiscal 2019 and expire through 2033. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately $1,796 for unrelated business activities. Management believes that it is more likely than not that deferred tax assets arising from net operating loss carryforwards will not be realizable. Accordingly, these are fully reserved at June 30, 2014 and 2013.

(Continued)

(Dollars in thousands)

(19) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2014 and 2013 was as follows:

	2014	2013
Medicare	48%	53%
TennCare/Medicaid	13	14
Other third-party payors	31	27
Patients	8	6
	100%	100%

(20) Disclosures about Fair Value of Financial Instruments

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer or settle a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820, *Fair Value Measurements*, establishes a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The classification of an investment within the hierarchy is based upon the pricing transparency or ability to redeem the investment and does not necessarily correspond to the perceived risk of that investment. Inputs are used in applying various valuation techniques that are assumptions, which market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, operating statistics, specific and broad credit data, liquidity statistics, recent transactions, earnings forecasts, future cash flows, market multiples, discount rates, and other factors.

Assets and liabilities measured and reported at fair value are classified within the fair value hierarchy as follows:

Level 1 – Valuations based on quoted market prices in active markets.

Level 2 – Investments that trade in markets that are considered to be active, but are based on dealer quotations or alternative pricing sources supported by observable inputs or investments that trade in markets that are not considered to be active, but are valued based on quoted market prices, dealer quotations, or alternative pricing sources supported by observable inputs.

Level 3 – Investments classified within Level 3 have significant unobservable inputs, as they trade infrequently or not at all.

The level in the fair value hierarchy within which a fair measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

(Continued)

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2014:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 30,674	—	—	30,674
Assets limited as to use:				
Stock mutual funds	148,453	—	—	148,453
Bond mutual funds	167,156	—	—	167,156
Cash and money market funds	50,916	—	—	50,916
Real estate funds	21,381	—	—	21,381
Alternative investments	—	—	41,067	41,067
Subtotal	418,580	—	41,067	459,647
Long-term investments:				
Stock mutual funds	17,741	—	—	17,741
Bond mutual funds	11,420	—	—	11,420
Cash and money market funds	230	—	—	230
Real estate funds	1,618	—	—	1,618
Subtotal	31,009	—	—	31,009
	$ 449,589	—	41,067	490,656
Liabilities:				
Derivatives liability	$ —	6,118	—	6,118
Total	$ —	6,118	—	6,118

(Continued)

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2013:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 55,958	—	—	55,958
Assets limited as to use:				
Stock mutual funds	109,356	—	—	109,356
Bond mutual funds	175,594	—	—	175,594
Cash and money market funds	42,923	—	—	42,923
Real estate funds	16,377	—	—	16,377
Alternative investments	—	—	36,520	36,520
Subtotal	400,208	—	36,520	436,728
Long-term investments:				
Stock mutual funds	12,228	—	—	12,228
Bond mutual funds	13,478	—	—	13,478
Cash and money market funds	190	—	—	190
Real estate funds	1,220	—	—	1,220
Subtotal	27,116	—	—	27,116
	$ 427,324	—	36,520	463,844
Liabilities:				
Derivatives liability	$ —	7,425	—	7,425
Total	$ —	7,425	—	7,425

The following methods and assumptions were used to estimate fair value of each class of instruments:

- *Cash and Cash Equivalents*

  The carrying amount approximates fair value due to the short maturities of these instruments.

- *Patient Accounts and Other Receivables*

  The net recorded carrying value approximates fair value due to the short maturities of these instruments.

- *Investments and Assets Limited as to Use*

  The fair values of investments and assets limited as to use are based on quoted market prices and quotes obtained from security brokers or, in the case of the limited partnerships, by the general partner.

(Dollars in thousands)

Wellmont also applies the measurement provisions of ASU No. 2009-12 to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. This guidance amends the previous guidance and allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value, in many instances may not equal fair value that would be calculated pursuant to ASC 820. The fair value of these investments was $41,067 and $36,520 at June 30, 2014 and 2013, respectively.

- *Accounts Payable and Accrued Expenses*

  The carrying amount approximates fair value due to the short maturities of these liabilities.

- *Estimated Third-Party Payor Settlements, Other Long-Term Liabilities*

  The carrying amount approximates fair market value due to the nature of these liabilities.

- *Long-Term Debt*

  The carrying amount of indebtedness with variable interest rates approximates its fair value because the variable rates reflect current market rates for indebtedness with similar maturities and credit quality. The fair value of indebtedness with fixed interest rates is based on rates assumed to be currently available for indebtedness with similar terms and average maturities. Fair value measurements of indebtedness are based on observable interest rates and maturity schedules that fall within Level 2 of the hierarchy of fair value inputs. The estimated fair value of revenue bonds, using current market rates, was estimated at $444,106 and $436,832 for the years ended June 30, 2014 and 2013, respectively. The carrying amount of other long-term debt reported in note 11 and on the consolidated balance sheet approximates the related fair value.

The following table presents additional information about Level 3 assets measured at fair value. Both observable and unobservable inputs may be used to determine the fair value of positions that the Health System has classified within the Level 3 category. As a result, the unrealized gains and losses for assets within the Level 3 category in the table below may include changes in fair value that were attributable to both observable and unobservable inputs.

	Alternative investments
Balance at June 30, 2012	$ 36,989
Total realized and unrealized gains (losses):	
Included in revenues and gains in excess of expenses and losses	(69)
Included in changes in net assets	1,113
Purchases, issuances, and settlements	(1,513)
Transfers into and/or out of Level 3 (net)	—
Balance at June 30, 2013	36,520

(Continued)

(Dollars in thousands)

		Alternative investments
Total realized and unrealized gains (losses):		
Included in revenues and gains in excess of expenses and losses	$	(3,161)
Included in changes in net assets		1,898
Purchases, issuances, and settlements		5,810
Transfers into and/or out of Level 3 (net)		—
Balance at June 30, 2014	$	41,067

There were no transfers between any of the levels during the years ended June 30, 2014 and 2013.

(21) Subsequent Events

On July 1, 2014, Wellmont sold its 60% interest in Takoma Regional Hospital to Adventist Health System (which also owned the other 40%). Cash in the amount of $11,700 was received prior to July 1, 2014 and is included in current liabilities.

On September 24, 2014, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee issued, on behalf of Wellmont, $21,335 of Hospital Revenue Refunding Bonds, Series 2014E. Under the terms of the bond indenture, the proceeds were used to establish a fund to advance refund $19,580 of the Hospital Revenue Bonds, Series 2006C upon their call date in 2016. The Series 2014E Bonds were issued as tax-exempt and were issued in accordance with the Master Trust Indenture dated May 1, 1991. Upon the issuance of the Series 2014E Bonds, a new Master Trust Indenture was implemented and replaced the one dated May 1, 1991.

Wellmont has evaluated subsequent events from the balance sheet date through October 24, 2014, the date at which the consolidated financial statements were issued. No other material subsequent events were identified for recognition and disclosed.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2015 and 2014

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

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KPMG LLP
Suite 1000
401 Commerce Street
Nashville, TN 37219-2422

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Wellmont Health System and affiliates, which comprise the consolidated balance sheets as of June 30, 2015 and 2014, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Wellmont Health System and affiliates as of June 30, 2015 and 2014, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Nashville, Tennessee
October 27, 2015

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2015 and 2014

(Dollars in thousands)

Assets		2015	2014
Current assets:			
Cash and cash equivalents	$	48,866	30,674
Assets limited as to use, required for current liabilities		3,651	4,066
Patient accounts receivable, less allowance for uncollectible accounts of approximately $33,297 and $38,007 in 2015 and 2014, respectively		112,299	117,265
Other receivables		11,238	14,685
Inventories		19,981	18,684
Prepaid expenses and other current assets		9,979	10,337
Total current assets		206,014	195,711
Assets limited as to use, net of current portion		424,864	424,907
Land, buildings, and equipment, net		484,569	492,581
Other assets:			
Long-term investments		27,964	32,521
Investments in affiliates		7,214	18,221
Deferred debt expense, net		4,217	4,226
Goodwill		51,583	51,649
Other		525	520
		91,503	107,137
Total assets	$	1,206,950	1,220,336
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	18,626	18,015
Accounts payable and accrued expenses		101,871	90,547
Estimated third-party payor settlements		12,987	8,425
Current portion of other long-term liabilities		7,660	6,510
Other current liabilities		—	11,700
Total current liabilities		141,144	135,197
Long-term debt, less current portion		480,187	490,443
Other long-term liabilities, less current portion		39,097	43,866
Total liabilities		660,428	669,506
Net assets:			
Unrestricted		535,632	538,607
Temporarily restricted		6,960	8,214
Permanently restricted		1,323	1,319
Total net assets attributable to Wellmont		543,915	548,140
Noncontrolling interests		2,607	2,690
Total net assets		546,522	550,830
Commitments and contingencies			
Total liabilities and net assets	$	1,206,950	1,220,336

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2015 and 2014

(Dollars in thousands)

	2015	2014
Revenue:		
Patient service revenue	$ 838,277	788,910
Provision for bad debts	(47,307)	(45,644)
Net patient revenue less provision for bad debts	790,970	743,266
Other revenues	21,759	29,441
Total revenue	812,729	772,707
Expenses:		
Salaries and benefits	399,955	374,309
Medical supplies and drugs	168,678	166,676
Purchased services	75,749	73,674
Interest	17,757	18,350
Depreciation and amortization	58,569	50,058
Maintenance and utilities	39,764	36,978
Lease and rental	15,435	15,506
Other	30,128	32,312
Total expenses	806,035	767,863
Income from operations	6,694	4,844
Nonoperating gains (losses):		
Investment income	14,207	14,749
Derivative valuation adjustments	(563)	1,307
Loss on refinancing	(1,389)	(1,133)
Gain on revaluation of equity method investmen	—	14,744
Nonoperating gains, net	12,255	29,667
Revenue and gains in excess of expenses and losses before discontinued operations	18,949	34,511
Discontinued operations	(2,720)	(26,639)
Revenue and gains in excess of expenses and losses	16,229	7,872
Income attributable to noncontrolling interests	(866)	(1,540)
Revenues and gains in excess of expenses and losses attributable to Wellmont	15,363	6,332
Other changes in unrestricted net assets:		
Change in net unrealized (losses) gains on investments	(18,555)	28,333
Net assets released from restrictions for additions to land, buildings, and equipmen	2,712	901
Change in the funded status of benefit plans	(2,495)	(893)
(Decrease) increase in unrestricted net assets	(2,975)	34,673
Changes in temporarily restricted net assets:		
Contributions	2,545	2,707
Net assets released from temporary restrictions	(3,799)	(1,420)
(Decrease) increase in temporarily restricted net assets	(1,254)	1,287
Changes in permanently restricted net assets– investment income	4	8
Changes in noncontrolling interests:		
Income attributable to noncontrolling interests	866	1,540
Distributions to noncontrolling interests	(949)	(1,623)
Change in noncontrolling interests	(83)	(83)
Change in net assets	(4,308)	35,885
Net assets, beginning of year	550,830	514,945
Net assets, end of year	$ 546,522	550,830

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2015 and 2014

(Dollars in thousands)

	2015	2014
Cash flows from operating activities:		
Change in net assets	$ (4,308)	35,885
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	58,569	50,526
Gain on disposal of land, buildings, and equipment	(569)	(78)
Equity in earnings of affiliated organizations	(405)	(1,764)
Distributions from affiliated organizations	231	3,484
Amortization of deferred financing costs	534	426
Net realized and unrealized loss (gain) on investments	18,182	(31,302)
Provision for bad debts	47,307	40,237
Change in fair value of derivative instruments	1,637	(1,307)
Loss on refinancing	1,389	1,133
Gain on revaluation of equity method investment	—	(14,744)
Loss on impairment	66	22,456
Changes in assets and liabilities, net of acquisitions:		
Patient accounts receivable	(42,341)	(44,839)
Other current assets	(939)	(1,711)
Other assets	3,442	3,297
Accounts payable and accrued expenses	6,240	5,474
Estimated third-party payor settlements	4,562	1,268
Other current liabilities	(10,550)	11,358
Other liabilities	(6,925)	2,998
Net cash provided by operating activities	76,122	82,797
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	100,324	123,193
Purchase of investments	(101,791)	(141,095)
Purchase of land, buildings, and equipment	(39,044)	(86,879)
Proceeds from the sale of buildings and equipment	2,424	2,434
Cash paid for acquisitions	—	(22,637)
Net cash used in investing activities	(38,087)	(124,984)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	21,335	128,623
Payments on long-term debt	(40,746)	(111,092)
Payment of debt issuance costs	(432)	(628)
Net cash (used in) provided by financing activities	(19,843)	16,903
Net increase (decrease) increase in cash and cash equivalents	18,192	(25,284)
Cash and cash equivalents, beginning of year	30,674	55,958
Cash and cash equivalents, end of year	$ 48,866	30,674

Supplemental disclosures of noncash items:

Wellmont entered into capital lease obligations for buildings and equipment in the amount of $8,284 and $1,345 in 2015 and 2014, respectively.

Additions to property and equipment financed through current liabilities of $5,084 and $3,770 in 2015 and 2014, respectively.

See accompanying notes to consolidated financial statements.

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont), a Tennessee not-for-profit corporation, currently operates six acute care hospitals in Tennessee and Virginia that include Bristol Regional Medical Center in Bristol, Tennessee, Holston Valley Medical Center in Kingsport, Tennessee, Lonesome Pine Hospital in Big Stone Gap, Virginia, Hawkins County Memorial Hospital in Rogersville, Tennessee, Hancock County Hospital in Sneedville, Tennessee, and Mountain View Regional Medical Center in Norton, Virginia.

The consolidated financial statements also include the operations of:

- Wellmont Cardiology Services and Wellmont Medical Associates, which operate physician practices.
- Wellmont Madison House and Wellmont Wexford House, which operate assisted living, adult day care, and skilled nursing facilities.
- Wellmont Foundation, which conducts fund-raising activities for the benefit of Wellmont.
- Wellmont Integrated Network, LLC, which is an accountable care organization.
- Wellmont Insurance Company SPC, Ltd, which is a captive insurance company.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection services, provide other healthcare-related services, and invest in affiliates and other activities.

All significant intercompany accounts and transactions have been eliminated in the accompanying consolidated financial statements.

Wellmont's continuing operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

The following are included in discontinued operations:

- As of October 1, 2013, Wellmont closed Lee Regional Medical Center in Pennington Gap, Virginia. The losses of $2,717 and $26,091, for the years ended June 30, 2015 and 2014, respectively, including an impairment loss of $22,456, for the year ended June 30, 2014, are included in discontinued operations
- As of May 17, 2013, a subsidiary of Wellmont ceased operating its sleep labs, which were managed by a third party. The gains (losses) of $3 and ($292) for the years ended June 30, 2015 and 2014, respectively, are included in discontinued operations.
- As of September 23, 2010, Wellmont sold the majority of its retail pharmacy's assets to a national pharmacy company. The gains (losses) of ($6) and $45 for the years ended June 30, 2015 and 2014, respectively, are included in discontinued operations.
- As of April 30, 2009, Wellmont closed Jenkins Community Hospital in Jenkins, Kentucky. The gains (losses) of $0 and ($301) for the years ended June 30, 2015 and 2014, respectively, are included in discontinued operations.

(2) Significant Accounting Policies

A summary of significant accounting policies is as follows:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) 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. Significant estimates include allowances for contractual adjustments and bad debts; third-party payor settlements; valuation of investments, land, buildings, equipment, and goodwill; and self-insurance and other liabilities. Actual results could differ from these estimates.

(b) Cash and Cash Equivalents

Wellmont considers all highly liquid investments with a maturity of three months or less when purchased, excluding amounts whose use is limited by board of directors' designation or other arrangements under trust agreements, to be cash equivalents.

(c) Investments

Marketable equity securities and debt securities are recorded at fair value and classified as other than trading. Fair value is determined primarily using quoted prices (unadjusted) in active markets for identical assets or liabilities that Wellmont has the ability to access at the measurement date. However, Wellmont also uses observable and unobservable inputs for investments without quoted market prices to determine the fair value of certain investments at the measurement date. Investments in limited partnerships are recorded at net asset value as determined by the partnership. Wellmont has adopted the measurement provisions of Accounting Standards Update (ASU) No. 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, to certain investments in funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. Investments in affiliates in which Wellmont has significant influence but does not control are reported on the equity method of accounting, which represents Wellmont's equity in the underlying net book value. Long-term investments include those investments that have not been designated by the board of directors for specific purposes and are also not intended to be used for the liquidation of current liabilities. Investment income is recognized when earned.

Realized gains and losses are determined on the specific-identification method and included in investment income with interest and dividends. Investment income is reported net of related investment fees. Unrealized gains and losses are included in other changes in unrestricted net assets except for losses determined to be other than temporary, which are considered realized losses and included in investment income.

(Continued)

(d) Assets Limited as to Use

Assets limited as to use primarily include designated assets set aside by the board of directors for future capital improvements, over which the board of directors retains control and may, at its discretion, subsequently use for other purposes, and assets held by trustees under bond indenture and self-insurance arrangements. Amounts required to meet current liabilities of Wellmont have been reclassified to current assets in the accompanying consolidated balance sheets.

(e) Inventories

Inventories are stated at the lower of cost or market value and are valued principally by the first-in, first-out, and average-cost methods.

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, if purchased, or fair value at date of donation. Depreciation is computed using the straight-line method based on the estimated useful life of the asset, ranging from 3 to 40 years. Buildings and equipment held under capital leases are recorded at net present value of future lease payments and are amortized on a straight-line basis over the shorter of the lease term or estimated useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Upon sale or retirement of land, buildings, or equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss, if any, is included in other revenues on the consolidated statements of operations and changes in net assets. 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.

Wellmont evaluates long-lived assets for impairment on annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset.

(g) Goodwill

Wellmont follows ASU No. 2010-07, *Not for Profit Entities: Mergers and Acquisitions*, which in part requires healthcare entities to follow Accounting Standards Codification (ASC) Topic 350-20-35, *Intangibles – Goodwill and Other* along with ASU 2011-08, *Testing Goodwill for Impairment*. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. An entity has the option to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If, after assessing the totality of events or circumstances, an entity determines it is not more likely than not that the fair value of a reporting unit

(Continued)

is less than its carrying amount, then performing the two-step impairment test is unnecessary. The more-likely than-not threshold is defined as having a likelihood of more than 50%. However, if an entity concludes otherwise, then it is required to perform the first step of the two-step impairment test by calculating the fair value of the reporting unit and comparing the fair value with the carrying amount (including goodwill) of the reporting unit. If the carrying amount of a reporting unit exceeds its fair value, then the entity is required to perform the second step of the goodwill impairment test to measure the amount of the impairment loss. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step two does not need to be performed. The annual impairment test is performed as of June 30.

(h) Deferred Debt Expense

Deferred debt expense is amortized over the life of the related bond issues using the effective-interest method.

(i) Derivative Financial Instruments

As further described in note 13, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) Asset Retirement Obligations

Asset retirement obligations (AROs) are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value, and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, Wellmont records period-to-period changes in the ARO liability resulting from the passage of time and revisions to either the timing or the amount of the original estimate of undiscounted cash flows. Wellmont derecognizes ARO liabilities when the related obligations are settled.

(k) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by Wellmont has been limited by donors to a specific-time period or purpose. Permanently restricted net assets have been restricted by donors to be

maintained by Wellmont in perpetuity. Generally, donors of permanently restricted assets permit use of all or part of the income earned on related investments for general or specific purposes.

Temporarily restricted net assets relate primarily to amounts held by the Foundation and include amounts restricted for future capital expenditures and for operations of such areas as children's healthcare services, hospice, and cancer care.

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2015 and 2014 primarily included amounts related to the purchase of equipment for pediatrics, cancer, and other healthcare operations.

Wellmont has adopted guidance issued by Financial Accounting Standards Board (FASB), which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA). Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of five individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. On the basis of historical experience, a significant portion of Wellmont's uninsured patients will be unable or unwilling to pay for the services provided. Therefore, Wellmont records a significant provision for bad debts related to uninsured patients in the period the services are provided. This provision for bad

debts is presented on the statements of operations as a component of net patient revenue. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

Patient accounts receivable are reported net of both an allowance for contractual adjustments and an allowance for uncollectible accounts. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, TennCare, Medicaid, and other third-party payment programs. Wellmont's policy does not require collateral or other security for patient accounts receivable. Wellmont routinely obtains assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans, or policies.

(m) Revenue and Gains in Excess of Expenses and Losses

The consolidated statements of operations and changes in net assets include revenue and gains in excess of expenses and losses. Changes in unrestricted net assets that are excluded from revenue and gains in excess of expenses and losses, consistent with industry practice, include changes in net unrealized gains (losses) on investments other than trading securities, changes in the funded status of Wellmont's defined-benefit plan, contributions of long-lived assets, including assets acquired using contributions that, by donor restriction, were to be used for the purposes of acquiring such assets, and cumulative effects of changes in accounting principles.

For purposes of financial statement display, those activities directly associated with Wellmont's mission of providing healthcare services are considered to be operating activities. Nonoperating activities primarily include investment and related activities. Other operating revenues primarily include cafeteria, rental, meaningful use incentives, and income from affiliates.

(n) Contributed Resources

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted contributions, and are excluded from revenue and gains in excess of expenses and losses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. Gifts are reported as either a temporarily or permanently restricted contribution if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or a purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions. Unrestricted contributions are included in other revenues.

(o) Federal Income Taxes

The Wellmont entities are primarily classified as organizations exempt from federal income taxes under Section 501(a) as entities described in Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been included for these entities in the consolidated financial statements. The operations of Wellmont, Inc. are subject to state and federal income taxes, which are accounted for in accordance with ASC Topic 740, *Income Taxes*; however, such amounts are not material.

(p) Recently Adopted Accounting Standards

In May 2015, the FASB issued ASU No. 2015-07, *Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share (or Its Equivalent)*. This ASU removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. The amendments also remove the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. Rather, those disclosures are limited to investments for which the entity has elected to measure the fair value using the practical expedient. Adoption of this standard should be applied on a retrospective basis. Wellmont early implemented the provisions of ASU 2015-07 during fiscal year 2015, retrospectively effective July 1, 2014.

(q) Reclassifications

Certain 2014 amounts have been reclassified to conform to the 2015 consolidated financial statement presentation. The reclassifications had no impact on total assets or changes in net assets.

(3) Business Combinations and Goodwill

On November 30, 2013, Wellmont purchased 100% of the membership interest in Wexford House from Residential Healthcare Affiliates. Wexford House is a skilled nursing facility, which serves residents of Sullivan County, Tennessee and the surrounding communities. The facility provides short- and long-term medical and rehabilitation care. In addition, on March 31, 2014, Wellmont purchased the remaining 25% interest in Holston Valley Imaging Center (HVIC), which included the remaining 50% governance interest from Blue Ridge Radiology Investment. The assets acquired and liabilities assumed under each acquisition were recorded at their estimated fair value in accordance with ASC 805.

(Dollars in thousands)

The following table summarizes the consideration paid and the estimated fair value of the assets acquired and liabilities assumed at the business combination date:

		Wexford	HVIC
Consideration:			
Cash	$	14,770	7,867
Fair value of Wellmont's equity interest in HVIC held before acquisition		—	23,601
	$	14,770	31,468
Recognized amounts of identifiable assets acquired and liabilities assumed:			
Current assets	$	2,976	2,474
Other assets		5,277	241
Current liabilities		(564)	(863)
Long-term liabilities		(608)	—
Total identifiable net assets		7,081	1,852
Goodwill		7,689	29,616
	$	14,770	31,468

Wellmont recognized a gain of $14,744 as a result of remeasuring to fair value its 75% equity interest in HVIC held before the business combination. The gain is included in nonoperating gains (losses) on the consolidated statement of operations for the year ended June 30, 2014.

A summary of goodwill for the years ended June 30 is as follows:

		2014	Additions	Decreases	2015
Goodwill	$	51,649		(66)	51,583

		2013	Additions	Decreases	2014
Goodwill	$	15,096	37,305	(752)	51,649

(Continued)

(Dollars in thousands)

(4) 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 consolidated statements of operations and changes in net assets is as follows for the years ended June 30:

		2015	2014
Gross patient service revenue	$	2,973,219	2,683,891
Less:			
Contractual adjustments and other discounts		(2,069,377)	(1,838,900)
Charity care		(65,565)	(56,081)
Net patient service revenue before provision for bad debts		838,277	788,910
Less provision for bad debts		(47,307)	(45,644)
Net patient service revenue	$	790,970	743,266

Wellmont's allowance for doubtful accounts is predominantly for self-pay patients and patient balances remaining after third-party payments. The provision for bad debts increased $1,663 from fiscal 2014 to fiscal 2015 and the net write-offs increased $30,169 from fiscal 2014 to fiscal 2015. The increase in write-offs was due to the implementation of a new billing system in the last quarter of fiscal 2014, which then caused a catch up on write-offs in fiscal 2015. Wellmont has not changed its charity care or uninsured discount policies during fiscal 2015. Wellmont does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(5) Third-Party Reimbursement Arrangements

Wellmont renders services to patients under contractual arrangements with the Medicare and Medicaid programs. The Medicaid programs in Tennessee and Virginia are contracted by each state to commercial managed care contractors to cover Medicaid eligible enrollees. Amounts earned under these contractual arrangements are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Management believes that adequate provision has been made for any adjustments that may result from such reviews. Participation in these programs subjects Wellmont to significant rules and regulations; failure to adhere to such could result in fines, penalties, or expulsion from the programs.

Wellmont contracts with various managed care organizations under the Medicaid programs. Reimbursement for both inpatient and outpatient services is based upon prospectively determined rates, including diagnostic-related group assignments, fee schedules, and per diem amounts. Reimbursement under the Medicaid program is also based upon prospectively determined amounts.

The Medicare program pays for the costs of inpatient services on a prospective basis. Payments are based upon diagnostic-related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. Wellmont receives additional payments from Medicare based on the provision

(Dollars in thousands)

of services to a disproportionate share of Medicaid-eligible and other low-income patients. Outpatient services are also reimbursed primarily on a prospectively determined basis.

Net patient service revenue in 2015 and 2014 related to Medicare and TennCare/Medicaid and net patient accounts receivable at June 30, 2015 and 2014 from Medicare and TennCare/Medicaid were as follows:

		2015	2014
Net patient service revenue:			
Medicare	$	337,813	304,713
TennCare/Medicaid		49,883	37,216
Net patient accounts receivable:			
Medicare	$	33,101	44,480
TennCare/Medicaid		6,474	6,817

Wellmont has filed cost reports with Medicare and Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2011 and audit adjustments have been received and considered for certain hospitals and year-ends through June 30, 2013.

Wellmont has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, per diem rates, and discounts from established charges.

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately $2,735 and $3,334 in 2015 and 2014, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2015 could differ materially from actual settlements based on the results of third-party audits.

(6) Meaningful Use Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record (EHR) technology. The Medicare incentive payments are paid out to qualifying hospitals and physician groups over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals, and physician groups must meet EHR “meaningful use” criteria that become

more stringent over three stages as determined by Centers for Medicare & Medicaid Services (CMS). Medicaid programs and payment schedules vary from state to state.

For fiscal years ended June 30, 2015 and 2014, Wellmont recorded $3,233 and $7,211, respectively, in other operating revenue related to the EHR and meaningful use incentives. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

Amounts recognized represent management's best estimates for payments ultimately expected to be received based on estimated discharges, charity care, and other input data. Subsequent changes to these estimates will be recognized in other operating revenue in the period in which additional information is available. Such estimates are subject to audit by the federal government or its designee.

(7) Charity Care and Community Services

Wellmont accepts all patients within its primary service area regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies that consider, among other factors, generally recognized poverty income levels.

Wellmont maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone and estimated costs incurred for services and supplies furnished under its charity care policy. Costs incurred are estimated based on the ratio of total operating expenses to gross charges applied to charity care charges. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were $69,565 and $17,254, and 2.66%, respectively, for the year ended June 30, 2015 and $56,081, $14,567, and 2.39%, respectively, for the year ended June 30, 2014.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and state indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled $37,818 and $37,432 for the years ended June 30, 2015 and 2014, respectively.

Wellmont also provides services to the community at large for which it receives little or no payment. Health evaluations, screening programs, and specific services for the elderly and homebound are other services supplied. Wellmont also provides public health education, trains new health professionals, and conducts health research.

(8) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately $405 and $1,764 for the years ended June 30, 2015 and 2014, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont received distributions of $231 and $3,484 during 2015 and 2014, respectively, which reduced Wellmont's overall investment in the affiliates.

(Dollars in thousands)

The following table summarizes the unaudited aggregate financial information of Wellmont's investments in affiliates:

		2015	2014
Total assets	$	116,359	136,824
Total liabilities		28,284	38,396
Total net assets	$	88,075	98,428
Net revenues	$	150,253	201,639
Expenses		141,825	191,023
Revenues in excess of expenses	$	8,428	10,616

Wellmont's investment in these affiliates and its ownership percentage as of June 30, 2015 and 2014 is as follows:

		Amount		Percentages	
		2015	2014	2015	2014
Takoma Regional Hospital	$	—	10,763	0%	60%
Advanced Home Care (AHO)		6,092	6,092	6	6
Others		1,122	1,366	4%-50%	25%–50%
	$	7,214	18,221		

As of July 1, 2014, Wellmont sold the 60% ownership in Takoma Regional Hospital. Prior to this transaction and although Wellmont's ownership percentage in Takoma Regional Hospital was greater than 50%, Wellmont did not consolidate this entity because Wellmont only had a 50% representation on the board and did not have control over the entity. Wellmont provides billing, management, and professional services to some of the affiliates. Income recognized by Wellmont for the services was $173 in 2014 and is included in other revenues. Included in other receivables are $86 and $242 as of June 30, 2015 and 2014, respectively, of amounts due to Wellmont from these entities.

(Continued)

(Dollars in thousands)

(9) Investments

Long-term investments, including assets limited as to use, at June 30 are reported at fair value and consist of the following:

	2015	2014
Assets limited as to use by Board for capital improvements:		
Stock mutual funds	$ 155,165	148,453
Bond mutual funds	157,091	167,156
Cash and money market funds	9,530	5,904
Real estate funds	17,967	21,381
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):		
Liquid	14,911	14,215
Illiquid	28,012	26,852
	382,676	383,961
Assets limited as to use under self-insurance agreements:		
Cash and money market funds	16,992	16,051
Assets limited as to use under bond indenture agreements:		
Cash and money market funds	28,847	28,961
Less assets limited as to use that are required for current liabilities	3,651	4,066
Assets limited as to use, net of current portion	$ 424,864	424,907
Long-term investments:		
Stock mutual funds	$ 15,627	17,741
Bond mutual funds	9,535	11,420
Right of first refusal	1,512	1,512
Cash, money market funds, and certificates of deposit	242	230
Real estate funds	1,048	1,618
Total long-term investments	$ 27,964	32,521

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately $15,917 as of June 30, 2015 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which $1,053 was paid subsequent to June 30, 2015.

Wellmont's investments are concentrated in stock and bond mutual funds. In the event of a downward trend in the stock and bond markets, Wellmont's overall market value of net assets could be adversely affected by a material amount. Investments in alternative investments are generally illiquid investments whose value is

(Dollars in thousands)

determined by the general partner such as hedge funds, private equity, commingled funds, and real estate funds. Distributions are only at the discretion of a voting majority of the general partners.

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, Wellmont recognized other-than-temporary impairment losses of $845 and $0 on investments as of June 30, 2015 and 2014, respectively. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2015 and 2014 were as follows:

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2015:						
Alternative investments	$ 396	2,975	12	459	408	3,434
Mutual funds	3,282	128,081	8,508	72,699	11,790	200,780
	$ 3,678	131,056	8,520	73,158	12,198	204,214

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2014:						
Alternative investments	$ —	—	647	878	647	878
Mutual funds	16	1,655	3,632	119,716	3,648	121,371
	$ 16	1,655	4,279	120,594	4,295	122,249

Investment income is comprised of the following for the years ended June 30:

	2015	2014
Interest and dividends, net of amounts capitalized	$ 13,677	11,780
Realized gains on investments, net	530	2,969
Investment income, net	$ 14,207	14,749
Change in net unrealized gains on investment	$ (18,555)	28,333

(Continued)

(Dollars in thousands)

(10) Land, Buildings, and Equipment

Land, buildings, and equipment at June 30 consist of the following:

	2015	2014
Land	$ 49,536	49,825
Buildings and improvements	530,904	523,069
Equipment	517,990	490,805
Buildings and equipment under capital lease obligations	54,316	46,031
	1,152,746	1,109,730
Less accumulated depreciation	(674,587)	(623,930)
	478,159	485,800
Construction in progress	6,410	6,781
Land, buildings, and equipment	$ 484,569	492,581

Depreciation expense for the years ended June 30, 2015 and 2014 was $58,569 and $50,058, respectively. Included in depreciation expense is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was $26,168 and $21,789 as of June 30, 2015 and 2014, respectively.

(11) Other Long-Term Liabilities

Other long-term liabilities at June 30 consist of the following:

	2015	2014
Workers' compensation liability	$ 12,195	11,096
Professional and general liability	15,465	15,940
Postretirement benefit obligation	2,487	2,633
Asset retirement obligation	3,353	3,139
Deferred gain on sale of assets	1,327	409
Derivative liability	(90)	6,118
Pension benefit liability	12,020	11,041
	46,757	50,376
Less current portion	(7,660)	(6,510)
Total other long-term liabilities	$ 39,097	43,866

(Continued)

(Dollars in thousands)

(12) Debt

(a) Long-Term Debt

Long-term debt consists of the following at June 30:

	2015	2014
Hospital Refunding Bonds, Series 2014A	$ 12,137	14,242
Hospital Refunding Bonds, Series 2014B	49,615	52,275
Hospital Refunding Bonds, Series 2014C	18,836	20,836
Hospital Revenue Bonds, Series 2014D	13,575	13,575
Hospital Revenue Bonds, Series 2014E	21,335	—
Hospital Revenue Refunding Bonds, Series 2011	74,410	75,300
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	180,420	200,000
Project Odyssey 2012 Tax-Exempt Master Lease/Sublease Financing	34,341	40,589
Notes payable	9,771	10,232
Capital lease obligations	23,864	19,749
Other	308	674
	493,612	502,472
Unamortized premium	5,201	5,986
	498,813	508,458
Less current maturities	(18,626)	(18,015)
	$ 480,187	490,443

(b) Series 2014 Bonds

On June 25, 2014, Wellmont (a) refunded the Revenue Bonds, Series 2003, the Revenue Refunding Bonds, Series 2005, and the Revenue Bonds, Series 2010 (Bank Qualified), with the proceeds of the Hospital Revenue Refunding Bonds, Series 2014A, Series 2014B, and Series 2014C and (b) issued Series 2014D. The Series 2014A through Series 2014E Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2003, the Revenue Refunding Bonds, Series 2005, a portion of the Revenue Refunding Bonds, Series 2006C, and the Revenue Bonds, Series 2010 (Bank Qualified) and to issue new debt in the amount of $13,575 to reimburse Wellmont for the purchase price of Wellmont Wexford House and to pay closing costs of issuing the Series 2014D Bonds. On September 1, 2014, the 2014E Bonds were issued by The Health, Educational, and Housing Facilities board of the County of Sullivan, Tennessee

(Continued)

on behalf of Wellmont. All of the Series 2014 Bonds were issued as tax-exempt and were issued in accordance with the Amended and Restated Master Trust Indenture dated September 1, 2014.

The Series 2014 Bonds were issued with four maturities; Series 2014A for $14,242, maturing September, 1, 2019, Series 2014B for $52,275, maturing September 1, 2032, Series 2014C for $20,836, maturing September 1, 2024, Series 2014D for $13,575, maturing September 1, 2040, and Series 2014E for $21,335, maturing September 1, 2022. Principal and interest will be paid annually, except there will be interest only paid on the Series 2014D through September 2030 with principal payments beginning on September 1, 2031 and on the Series 2014E through September 2016 with principal payments beginning September 1, 2017.

Interest on the Series 2014 Bonds is 100% of LIBOR plus a quotient of applicable spread divided by 67%. Accrued interest is paid monthly in arrears. Interest rates on the 2014A, 2014B, 2014C, 2014D and 2014E Bonds were .89%, .99%, .97%, .97% and .97%, respectively, as of June 30, 2015.

The Series 2014C and Series 2014D Bonds can be called by the bondholders June 1, 2021 and each successive year after that until they mature. The Series 2014E Bonds can be called by the bondholders September 1, 2021 and on June 1 each successive year after that until they mature.

(c) Project Odyssey 2012 Tax-Exempt Master Lease/Sublease Financing

On December 1, 2012, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (as Lessee) and Wellmont (as Sub-Lessee) entered into a Master Equipment Lease and Sublease Agreement with Banc of America Public Capital Corp (the Lessor). The proceeds of this Master Lease were used to finance an electronic medical records system consisting of an EpicCare Inpatient Clinical System and an EpicCare Ambulatory Electronic Medical Records System inclusive of hardware, software, and implementation services. The Sub-Lessee authorized the Lessor to take a security interest in the entire System although only certain components of the System were funded under this Master Lease with the rest funded by Bank of America N.A. and Sub-Lessee. During the fiscal year ended June 30, 2014, Wellmont received two draws totaling $26,349. Each lease term shall commence and interest shall begin to accrue on the date any funds are advanced by Wellmont. The first six lease payments under each agreement consist only of an interest component and the remaining 78 lease payments consist of a principal component and an interest component. Commencing on June 30, 2013, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Each agreement will have an interest component based on a fixed rate of interest and payable with respect to the amount of funds that the Lessor has advanced. The rates of interest range from 1.45% to 1.97%.

(d) Series 2011 Bonds

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. Under the terms of the bond indenture, the proceeds were used to advance refund the Revenue Bonds, Series 2006A and to pay the costs of issuing the Series 2011 Bonds.

In order to refund the Series 2006A Bonds, Wellmont made a tender offer to the holders of the Series 2006A Bonds. The holders of all outstanding Series 2006A Bonds agreed to tender their Series 2006A Bonds to Wellmont. Proceeds of the Series 2011 Bonds were used to pay the purchase price of Series 2006A Bonds tendered for purchase. All outstanding Series 2006A Bonds were purchased by the Wellmont on the date of issuance of the Bonds and were immediately surrendered to the trustee for the Series 2006A Bonds for retirement and cancellation.

The Series 2011 Bonds were issued with two maturities of $42,385 and $33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2013 and ending on September 1, 2026 in annual amounts ranging from $865 to $4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from $4,980 to $6,300. The Series 2011 Bonds were issued as fixed-rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(e) Series 2007 Bonds

On July 24, 2007, The Virginia Small Business Financing Authority issued, on behalf of Wellmont, $55,000 of Hospital Revenue Bonds, Series 2007A. The Series 2007A Bonds, with other methods of financing, were used to purchase the assets of Mountain View Regional Medical Center and Lee Regional Medical Center.

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $360 to $2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of $29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.250%.

(f) Series 2006 C

On October 26, 2006, The Health, Educational, and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, $200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation, and equipping of an operating room and related facilities at Hawkins County Memorial Hospital.

Principal on outstanding Series 2006C Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $1,605 to $25,330 commencing on September 1, 2017 through September 1, 2036. The outstanding bonds accrue interest at rates ranging from 5.00% to 5.25%.

(g) Master Trust Indenture

The master trust indenture and loan agreements for the 2014, 2011, 2007, and 2006 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

Funds held by the trustee related to the various revenue bonds are available for specific purposes. The bond interest and revenue funds may be used only to pay interest and principal on the bonds; the debt service reserve fund may be used to pay interest and principal if sufficient funds are not available in the bond interest and revenue funds. The original issue premium on all bond series outstanding are being amortized over the life of the bond issue using the effective-interest method.

(h) Notes Payable

In August 2011, Wellmont entered into a note agreement in the amount of $1,760 with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate with a ceiling of 7.75% and a floor of 4.00% and a maturity date of August 2016. At June 30, 2015 and 2014, $446 and $828, respectively, were outstanding on this note.

On October 17, 2012, Wellmont entered into a 10-year $12,500 term note payable with Bank of America, N.A. The proceeds were used for the EpicCare system and its implementation, among other general corporate purposes. The note payable has a fixed interest rate of 3.27% and a maturity date of December 13, 2022. At June 30, 2015 and 2014, $9,254 and $9,254, respectively, were outstanding on this note.

On January 4, 2013, Wellmont entered into a three-year $193 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of December 2015. At June 30, 2015 and 2014, $45 and $107, respectively, were outstanding on this note.

On March 25, 2013, Wellmont entered into a three-year $47 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of August 2016. At June 30, 2015 and 2014, $26 and $43, respectively, were outstanding on this note.

(Continued)

(Dollars in thousands)

(i) Capital Lease Obligations

Assets under capital leases are included in property and equipment and have a net carrying value of $28,148 and $24,242 as of June 30, 2015 and 2014, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 2.1% to 12.0%.

(j) Long-Term Debt Maturities Schedule

Bond maturities in accordance with the terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2015 are as follows:

2016	$	18,626
2017		17,722
2018		20,059
2019		20,027
2020		20,505
Thereafter		396,673
	$	493,612

Interest paid for the years ended June 30, 2015 and 2014 was $19,881 and $18,899, respectively, net of amounts capitalized. Interest costs of $210 and $1,444 were capitalized in 2015 and 2014, respectively.

(13) Derivative Transactions

Wellmont is and has been a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to postcollateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2015 and 2014, Wellmont was not required to postcollateral related to its swaps.

Market risk is the adverse effect on the value of a derivative instrument that results from a change in interest rates. The market risk associated with interest-rate contracts is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2015 and 2014 of approximately $90 and $(6,118), respectively, is included in other long-term liabilities in the

(Dollars in thousands)

consolidated balance sheets. The change in the fair value of the derivative instruments was approximately $1,637 and $1,307, respectively, in 2015 and 2014 and is included in nonoperating gains in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. Effective May 28, 2015, Wellmont terminated and settled three of the interest rate swaps resulting in a loss of $2,200 included in Nonoperating gains (losses) in the consolidated statements of operations and changes in net assets. The following is a summary of the interest rate swap information as of June 30, 2015:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2011	$ 75,300	May 5, 2011	September 1, 2032	1.220%	6.249%	$ 90
							$ 90

The following is a schedule detailing the swap information as of June 30, 2014:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset (liability)
Total return swap	Series 2011	$ 75,300	May 5, 2011	September 1, 2032	1.410%	6.222%	$ 987
Pay fixed interest rate swap	*	52,275	December 13, 2005	September 1, 2016	3.548	0.101	(3,323)
Basis swap	*	56,465	September 1, 2002	September 1, 2032	0.060	0.173	(1,127)
Pay fixed interest rate swap	*	27,575	October 24, 2003	September 1, 2021	3.613	0.104	(2,655)
							$ (6,118)

* Previously designated bond series has been refinanced.

(14) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined-contribution retirement plan (Retirement Plan) that covers substantially all employees. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 2% (after October 1, 2013) and 3% (before October 1, 2013) of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 2.4% (after October 1, 2013) and 3% (before October 1, 2013) of each participant's wages. The total pension expense related to the Retirement Plan was $8,841 and $10,687 for the years ended June 30, 2015 and 2014, respectively.

A predecessor to Wellmont sponsored a noncontributory, defined-benefit pension plan covering, substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. One of Wellmont's acquired hospitals also sponsored a defined-benefit pension plan covering substantially all its employees, but the two plans were merged on June 30, 2007 and effective June 30, 2010, the plan was frozen for all employees and no further benefits accrue.

(Dollars in thousands)

The defined-pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. The funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined-benefit pension plans as an asset or liability in its consolidated balance sheet and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. The defined-benefit pension plans use a June 30 measurement date.

The following table sets forth the funded status of the Plans, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

		2015	2014
Change in benefit obligation:			
Benefit obligation at beginning of year	$	56,291	50,749
Service cost		—	—
Interest cost		2,176	2,196
Actuarial loss(gain)		(886)	5,815
Benefits paid		(2,501)	(2,469)
Benefit obligation at end of year		55,080	56,291
Change in plan assets:			
Fair value of plan assets at beginning of year		45,250	40,357
Actual return on plan assets		(1,591)	4,960
Employer contribution		1,902	2,402
Benefits paid		(2,501)	(2,469)
Fair value of plan assets at end of year		43,060	45,250
Funded status	$	(12,020)	(11,041)
Amounts recognized in the accompanying consolidated balance sheets:			
Pension benefit liability (other long-term liabilities)	$	(12,020)	(11,041)

(Continued)

(Dollars in thousands)

		2015	2014
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:			
Unrecognized actuarial loss	$	18,901	16,777
Unrecognized prior service cost		—	—
Net amounts included as an accumulated charge to unrestricted net assets	$	18,901	16,777
Calculation of change in unrestricted net assets:			
Accumulated charge to unrestricted net assets, end of year	$	18,901	16,777
Reversal of accumulated charge to unrestricted net assets, prior year		(16,777)	(14,552)
Change in unrestricted net assets	$	2,124	2,225
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Actuarial loss (gain) arising during the year	$	3,869	3,665
Amortization of actuarial loss		(1,745)	(1,440)
Amortization of prior service cost		—	—
Net amounts recognized in unrestricted net assets	$	2,124	2,225

(Continued)

(Dollars in thousands)

		2015	2014
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2014:			
Amortization of net loss	$	2,200	1,810
Amortization of prior service cost		—	—
Estimated future benefit payments:			
Fiscal 2015		—	2,804
Fiscal 2016		2,882	2,894
Fiscal 2017		2,987	3,004
Fiscal 2018		3,079	3,093
Fiscal 2019		3,162	3,178
Fiscal 2020–2023		20,295	16,759
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		4.25%	4.00%
Weighted average rate of increase in future compensation levels		N/A	N/A
Components of net periodic benefit cost (benefit):			
Service cost	$	—	—
Interest cost		2,176	2,196
Expected return on plan assets		(3,164)	(2,810)
Amortization of net loss		1,745	1,440
Net periodic benefit cost	$	757	826
Weighted average assumptions used to determine net periodic benefit cost:			
Settlement (discount) rate		4.00%	4.50%
Expected long-term return on plan assets (HVMC)		7.00	7.00
Expected long-term return on plan assets (LPH)		7.00	7.00
Weighted average rate of increase in future compensation levels		N/A	N/A

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont has developed a plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

(Continued)

(Dollars in thousands)

The table below shows the target allocation and actual asset allocations as of June 30, 2015 and 2014:

Asset	Target allocation	2015	2014
Equity securities	47%	47%	48%
Fixed income	41	33	33
Cash	—	3	3
Other	12	17	16

Wellmont monitors the asset allocation and executes required recalibrations of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

A predecessor to Wellmont also participates in a health and welfare plan for its retirees. The plan provides postretirement medical and life insurance benefits to certain employees who meet minimum age and service requirements. Effective January 1, 1995, the death benefit was changed to provide a flat $5 benefit to all future retirees. During 1995, the medical program for retirees was amended to terminate medical benefits for any active employees who would not meet the full eligibility requirements of the program by January 1, 1996. The plan is contributory and contains other cost-sharing features such as deductibles and coinsurance.

The following table sets forth the postretirement plan's funded status, amounts recognized in the accompanying consolidated financial statements, and assumptions at June 30:

	Postretirement benefits	
	2015	2014
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 2,633	4,582
Interest cost	86	96
Plan participants contributions	16	17
Actuarial losses	(172)	(1,978)
Benefits paid	(76)	(84)
Benefit obligation at end of year	2,487	2,633
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	60	66
Plan participants contributions	16	17
Benefits paid	(76)	(83)
Fair value of plan assets at end of year	—	—
Funded status	$ (2,487)	(2,633)

(Continued)

(Dollars in thousands)

	Postretirement benefits	
	2015	**2014**
Amounts recognized in the consolidated balance sheets consist of:		
Noncurrent assets	$ —	—
Current liabilities	(179)	—
Noncurrent liabilities	(2,308)	(2,633)
Accumulated charge to unrestricted net assets	5,568	5,939
	$ 3,081	3,306

Amounts recognized as an accumulated credit to unrestricted net assets consist of the following:

	2015	**2014**
Net actuarial gain	$ 5,568	5,939

Net periodic benefic cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2015 and 2014 were as follows:

	Postretirement benefits	
	2015	**2014**
Net periodic benefit cost:		
Interest cost	$ 86	95
Amortization of net gain	(544)	(646)
Net periodic benefit recognized	(458)	(551)
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	(173)	(1,978)
Amortization of net gain	544	646
Total recognized in unrestricted net assets	371	(1,332)
Total recognized in net periodic benefit cost and unrestricted net assets	$ (87)	(1,883)

The net gain and prior service credit for the defined-benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $(544) and $(646),

(Continued)

(Dollars in thousands)

respectively. Weighted average assumptions used to determine benefit obligations for 2015 and 2014 were as follows:

	2015	2014
Discount rate	3.75%	3.50%
Rate of compensation increase	—	—
Healthcare cost trend rate	5.00	5.00

Weighted average assumptions used to determine net benefit cost for 2015 and 2014 were as follows:

	Postretirement benefits	
	2015	2014
Discount rate	3.50%	4.00%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

Wellmont's overall expected long-term rate of return on assets is 7%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 7.25% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2015.

The following table summarizes the effect of one-percentage-point increase/decrease in healthcare costs trends:

		2015	2014
Effect of one-percentage-point increase in healthcare cost trend on:			
Service and interest cost	$	5	4
Accumulated pension benefit obligation		143	132
Effect of one-percentage-point decrease in healthcare cost trend on:			
Service and interest cost	$	(5)	(3)
Accumulated pension benefit obligation		(124)	(116)

(Continued)

(Dollars in thousands)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2015 and 2014, respectively, were as follows:

	Fair value measurement at June 30, 2015 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 34,625	34,625	—	—
Cash and money market funds	1,121	1,121	—	—
Fixed income fund	3,721	—	3,721	—
	39,467	35,746	3,721	—
Alternative funds - recorded at net asset value	3,593			
Total	$ 43,060			

	Fair value measurement at June 30, 2014 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 36,546	36,546	—	—
Cash and money market funds	1,279	1,279	—	—
Fixed income fund	3,935	—	3,935	—
	41,760	37,825	3,935	—
Alternative funds - recorded at net asset value	3,490			
Total	$ 45,250			

(Continued)

(15) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers' compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont Insurance Company SPC, Ltd (the captive) was formed in 2014 as a wholly owned captive insurance company in the Cayman Islands. The captive holds Wellmont's self-insurance liabilities for professional and general liability and is funded by transfers from Wellmont Health System. These funds are included in assets limited as to use.

The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Workers' compensation expense under these programs amounted to approximately $4,612 and $3,695 for the years ended June 30, 2015 and 2014, respectively, and are included in salaries and benefits expense in the accompanying consolidated statements of operations and changes in net assets. All other self-insurance expense under these programs amounted to approximately $1,568 and $5,707 for the years ended June 30, 2015 and 2014, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2015 and 2014, Wellmont was involved in litigation relating to medical malpractice, workers' compensation and other claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2015 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2015 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

Wellmont is also self-insured for medical and other healthcare benefits provided to its employees and their families. A provision for estimated incurred but not reported claims has been provided in the consolidated financial statements.

(16) Commitments and Contingencies

Construction in progress at June 30, 2015 and 2014 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately $5,191 at June 30, 2015. Wellmont has entered into contracts of $5,191 related to these projects.

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was $15,453 and $15,506 for the years ended June 30, 2015

(Continued)

(Dollars in thousands)

and 2014, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2015 are as follows:

2016	$	10,018
2017		8,046
2018		6,692
2019		5,908
2020		5,062
Thereafter		13,822
	$	49,548

Wellmont has entered into contractual employment relationships with physicians to provide services to Wellmont physician practices that are intended to qualify under the employee safe harbor of the Anti-Kickback Statute and the employee exception of the Physician Self-Referral Law. These contracts have terms of varying lengths, guarantee certain base payments, and may provide for additional incentives based upon productivity.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, such matters as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes Wellmont is in compliance with fraud and abuse statutes and other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

(17) Functional Expense Disclosure

Wellmont provides healthcare services to residents within its geographic location. Expenses based upon functional classification related to providing these services during the years ended June 30 are as follows:

		2015	2014
Professional care of patients	$	652,458	643,618
Administrative and general		152,549	123,191
Fund-raising		1,028	1,054
	$	806,035	767,863

(Continued)

(Dollars in thousands)

(18) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate-company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately $111,000 at June 30, 2015, which begin expiring in fiscal 2019 and expire through 2033. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately $1,860 for unrelated business activities. Management believes that it is more likely than not that deferred tax assets arising from net operating loss carryforwards will not be realizable. Accordingly, these are fully reserved at June 30, 2015 and 2014.

(19) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2015 and 2014 was as follows:

	2015	2014
Medicare	43%	48%
TennCare/Medicaid	12	13
Other third-party payors	32	31
Patients	13	8
	100%	100%

(20) Disclosures about Fair Value of Financial Instruments

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer or settle a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820, *Fair Value Measurements*, establishes a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The classification of an investment within the hierarchy is based upon the pricing transparency or ability to redeem the investment and does not necessarily correspond to the perceived risk of that investment. Inputs are used in applying various valuation techniques that are assumptions, which market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, operating statistics, specific and broad credit data, liquidity statistics, recent transactions, earnings forecasts, future cash flows, market multiples, discount rates, and other factors. ASC Topic 820 permits, as a practical expedient, for the estimation of the fair value of investment in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value in many instance may not equal fair value that would be calculated pursuant to ASC Topic 820. In accordance with ASC Topic 820, investments measured using net asset value as a

practical expedient are not categorized within the fair value hierarchy, however, the amount measured is included to permit reconciliation of the fair value of investments included in the fair value hierarchy to the line items presented in the consolidated statement of operations and changes in net assets.

Assets and liabilities measured and reported at fair value are classified within the fair value hierarchy as follows:

Level 1 – Valuations based on quoted market prices in active markets.

Level 2 – Investments that trade in markets that are considered to be active, but are based on dealer quotations or alternative pricing sources supported by observable inputs or investments that trade in markets that are not considered to be active, but are valued based on quoted market prices, dealer quotations, or alternative pricing sources supported by observable inputs.

Level 3 – Investments classified within Level 3 have significant unobservable inputs, as they trade infrequently or not at all.

The level in the fair value hierarchy within which a fair measurement in its entirety falls is based on the lowest-level input that is significant to the fair value measurement in its entirety.

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2015:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 48,866	—	—	48,866
Assets limited as to use:				
Stock mutual funds	155,165	—	—	155,165
Bond mutual funds	157,091	—	—	157,091
Cash and money market funds	55,369	—	—	55,369
Real estate funds	17,967	—	—	17,967
	434,458	—	—	434,458
Alternative investments - recorded at net asset vaue				42,923
Subtotal				477,381
Long-term investments:				
Stock mutual funds	15,627	—	—	15,627
Bond mutual funds	9,535	—	—	9,535
Cash and money market funds	242	—	—	242
Real estate funds	1,049	—	—	1,049
Subtotal	26,453	—	—	26,453
	$ 460,911	—	—	503,834
Liabilities:				
Derivatives asset	$ —	90	—	90
Total	$ —	90	—	90

(Continued)

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2014:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 30,674	—	—	30,674
Assets limited as to use:				
Stock mutual funds	148,453	—	—	148,453
Bond mutual funds	167,156	—	—	167,156
Cash and money market funds	50,916	—	—	50,916
Real estate funds	21,381	—	—	21,381
	418,580	—	—	418,580
Alternative investments - recorded at net asset value				41,067
Subtotal				459,647
Long-term investments:				
Stock mutual funds	17,741	—	—	17,741
Bond mutual funds	11,420	—	—	11,420
Cash and money market funds	230	—	—	230
Real estate funds	1,618	—	—	1,618
Subtotal	31,009	—	—	31,009
	$ 449,589	—	—	490,656
Liabilities:				
Derivatives liability	$ —	6,118	—	6,118
Total	$ —	6,118	—	6,118

The following methods and assumptions were used to estimate fair value of each class of instruments:

- *Cash and Cash Equivalents*

  The carrying amount approximates fair value due to the short maturities of these instruments.

- *Patient Accounts and Other Receivables*

  The net recorded carrying value approximates fair value due to the short maturities of these instruments.

- *Investments and Assets Limited as to Use*

  The fair values of investments and assets limited as to use are based on quoted market prices and quotes obtained from security brokers or, in the case of the limited partnerships, by the general partner.

(Continued)

Alternative investments are not categorized within the fair value hierarchy because fair value is measured using the net asset (NAV) per share practical expedient. Wellmont's alternative investments' prices are obtained from the fund manager. For Wellmont's fund of funds, the manager receives account statements directly from independent administrators or the underlying hedge fund managers, who are responsible for the pricing of these funds. Before reliance on these valuations, the managers evaluate the investee fund's fair value estimation processes and control environment, the investee fund's policies and procedures for estimating fair value of underlying investments, the investee fund's use of independent third party valuation experts, the portion of the underlying securities traded on active markets, and the professional reputation and standing of the investee fund's auditor.

- *Accounts Payable and Accrued Expenses*

  The carrying amount approximates fair value due to the short maturities of these liabilities.

- *Estimated Third-Party Payor Settlements, Other Long-Term Liabilities*

  The carrying amount approximates fair market value due to the nature of these liabilities.

- *Long-Term Debt*

  The carrying amount of indebtedness with variable interest rates approximates its fair value because the variable rates reflect current market rates for indebtedness with similar maturities and credit quality. The fair value of indebtedness with fixed interest rates is based on rates assumed to be currently available for indebtedness with similar terms and average maturities. Fair value measurements of indebtedness are based on observable interest rates and maturity schedules that fall within Level 2 of the hierarchy of fair value inputs. The estimated fair value of revenue bonds, using current market rates, was estimated at $455,650 and $444,106 for the years ended June 30, 2015 and 2014, respectively. The carrying amount of other long-term debt reported in note 12 and on the consolidated balance sheet approximates the related fair value.

(21) Subsequent Events

On July 1, 2014, Wellmont sold its 60% interest in Takoma Regional Hospital to Adventist Health System (which also owned the other 40%). Cash in the amount of $11,700 was received prior to July 1, 2014 and is included in current liabilities as of June 30, 2014. Subsequently, during 2015, Adventist Health System and Wellmont have agreed in principle that Wellmont will repurchase Takoma in fiscal year 2016. Wellmont has evaluated subsequent events from the balance sheet date through October 27, 2015 the date at which the consolidated financial statements were issued. No other material subsequent events were identified for recognition or disclosure.

Exhibit 11.5

Attachment D

The Wellmont External Auditor Management Letters are considered confidential information and will be subsequently filed.

Exhibit 11.5

Attachment E

Wellmont - Rating Agencies Reports

STANDARD &POOR'S

RATINGSDIRECT®

August 24, 2009

Wellmont Health System, Tennessee; System

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Wellmont Health System, Tennessee; System

Credit Profile		
Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)		
Long Term Rating	BBB+/Stable	Outlook Revised
Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)		
Unenhanced Rating	BBB+(SPUR)/Stable	Outlook Revised
Virginia Small Business Fin Auth, Virginia		
Wellmont Hlth Sys, Tennessee		
Virginia Small Business Fin Auth (Wellmont Health System)		
Long Term Rating	BBB+/Stable	Outlook Revised

Many issues are enhanced by bond insurance.

Rationale

Standard & Poor's Ratings Services revised its rating outlook to stable from negative on bonds issued for Wellmont Health System, Tenn. by various issuers. At the same time, Standard & Poor's rating services affirmed its 'BBB+' long-term rating and 'BBB+' underlying ratings (SPUR) on the bonds.

The outlook revision reflects better-than-expected operating performance through the fiscal year ended June 30 (unaudited); the initial implementation of various expense and revenue cycle improvements expected to support improved performance on an ongoing basis; and the culmination of Wellmont's look-back into the previous management's historical accounting practices, which ultimately led to the restatement of fiscal 2007 audited results and a long delay in the release of the system's fiscal 2008 audit.

Wellmont's former CEO and its chief financial officer (CFO) left the organization in July 2008 and December 2008, respectively. After serving in an interim capacity since July 2008, Wellmont named Mike Snow permanent CEO in March 2009. Wellmont is currently operating with an experienced interim CFO while conducting the search for a permanent CFO.

The affirmed 'BBB+' rating reflects Wellmont's:

- Improving financial metrics, including positive (unaudited) fiscal 2009 operating income of $6.5 million (a 0.9% margin), which compared with operating losses in the previous two years;
- Acceptable 2.1x maximum annual debt services (MADS) coverage (or 1.8x on an operating lease adjusted basis), which remained consistent with prior years, despite the significant decline of investment income and other nonoperating revenues in fiscal 2009;
- A stabilized, although still constrained, balance sheet due to Wellmont's acquisition activity over the past five years. Current balance sheet metrics are characterized by 131 days' cash on hand, a moderately high 58% long-term debt to total capitalization, and unrestricted cash to long-term debt of 54%; and
- The system's solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems that have recently become more collaborative.

Further supporting the rating are revenue cycle, staffing, expense, and other identified operating improvements that generated $7 million of incremental operating income for fiscal 2009 and are budgeted to produce about $15 million in improvements for fiscal 2010.

Offsetting factors include current uncertainty related to Wellmont's direct-pay letter of credit (LOC) agreement with Bank of America N.A. (BofA). Wellmont is currently out of compliance with its debt-to-capitalization covenant related to the BofA reimbursement agreement. Wellmont had been operating under a forbearance agreement with BofA and management is in discussions with the bank over debt covenants and the extension of a $64 million direct-pay LOC related to Wellmont's series 2005 bonds. The LOC expires in December 2010. Management expects to reach a successful extension with BofA, but should an agreement not be reached, the level of puttable debt relative to unrestricted cash is manageable at 26%. Other potentially negative credit factors include the ultimate outcome of health care reform, which may result in a significant reduction in reimbursement to system hospitals, a decrease in current-year inpatient and surgical volumes relative to fiscal 2008 at Wellmont's two newest hospitals, Lee Regional and Mountain View Regional, which represent approximately 7% of Wellmont's net revenue, and additional competitive pressure facing Wellmont's Bristol Regional Medical Center, from a competitor's replacement hospital that is under construction in Abingdon, Va.

In connection with its year-end 2008 audit, Wellmont changed its outside auditing firm to KPMG. KPMG and the audit committee of Wellmont's board identified a number of accounting entries that it believed warranted further review and possible reclassification. That process resulted in a protracted delay in the release of 2008 audited results and the restatement of audited results for fiscal 2007.

Restated results

Although Wellmont's fiscal 2006 results were not restated, accounting errors related to 2006 were recorded as a negative $15.1 million adjustment to beginning fiscal 2007 net assets. Had 2006 results been restated, reported operating income would have been revised to $2.8 million. Fiscal 2007 restated results reflected a decrease in operating income to a negative $6.5 million, as per Standard & Poor's calculation, which treated the $8.5 million gain on sale of Wellmont's home-care affiliate as a nonoperating item. Management originally reported fiscal 2007 operating income as $9.2 million, excluding the $8.5 million gain. The accounting restatements related to numerous accounting entries including the reconciliation of cash, accounts receivable, third-party payor settlement liabilities, prepaid expenses, goodwill amortization, the capitalization and depreciation of buildings and equipment, accounts payable and accruals, as well as other assets and liabilities. There was no fraud or personal gain associated with any of the restatements.

A gross revenue pledge of the obligated group, and a mortgage on Wellmont's two largest hospitals, and the Lee Regional and Mountain View hospitals secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, and the three hospitals recently acquired. All of the systems entities are included in the analysis and all numbers cited in this report.

As of June 30, 2009, Wellmont had $454.3 million of bonded debt. Based upon the increased counterparty risk associated with Lehman bankruptcy, Standard & Poor's revised its Debt Derivative Profile (DDP) on Wellmont to an overall score of '3' on a scale of '1' to '4' with '1' representing the lowest risk and '4' the highest. The overall score of '3' reflects Standard & Poor's view that the risks associated with Wellmont's derivatives portfolio are

moderate at this time.

As of June 30, Wellmont's swap liability was $10.2 million; however, there was no required posted collateral. There have been no changes to Wellmont's swap portfolio since our last published report in January 2009.

Outlook

The return to a stable outlook reflects our increased comfort that Wellmont has identified and corrected the accounting issues that led to the restated 2007 results and the 2008 audit delay. Additionally, while current economic conditions, and the uncertainty whether limits on future Medicare, TennCare, and Virginia Medicaid reimbursement may constrain operations, we believe that management initiatives to reduce costs and improve Wellmont's revenue cycle will support a generally improving operating trend. In addition, as market conditions improve, Wellmont's liquidity metrics and cash flow coverage will improve. While we remain concerned about the system's balance sheet, particularly leverage, Wellmont's future capital spending plans are modest, as $45 million remains in the 2006C Project Fund, and management has no current plans to issue additional long-term debt. Should the balance sheet or operations unexpectedly weaken, a downgrade or the return to a negative outlook would be likely. By contrast, significant improvement to the balance sheet over time would be cause for a positive outlook revision and possibly an upgrade.

System And Market Profile

Wellmont Health System, created in 1996 with the merger of Bristol Regional Medical Center and Holston Valley Medical Center, began a series of acquisitions that significantly expanded its geographic footprint. In 1997, the system added Lonesome Pine Hospital, a 60-bed facility in Big Stone Gap, Va. In 2000, the 50-bed Hawkins County Memorial Hospital, located in Rogersville, Tenn., joined the system. In 2005, Wellmont opened Hancock county Hospital a 10-bed, critical-access hospital. In 2007, Wellmont acquired Lee Regional Medical Center, an 80-bed facility, and Mountain View Regional Medical Center, a 133-bed facility. Both hospitals are located in relatively rural areas of southwest Virginia.

Also in 2007, Wellmont acquired a 60% interest in Takoma Regional Hospital from Adventist Health System Sunbelt ('A+'). The 108-bed hospital is located in Greene County, Tenn., southwest of Wellmont's core markets. Although Wellmont acquired a 60% equity stake, Adventist Health System Sunbelt is the manager of the facility so it is not consolidated but is accounted for as an equity investment.

On April 30, 2009, Wellmont closed Jenkins Community Hospital and sold the hospital's property plant and equipment for a $1 million. Jenkins was a 25-bed critical-access hospital in Jenkins, Ky., about an hour and a half north of Kingsport. Jenkins, acquired in 2007, failed to meet management's financial targets -- having lost $1.1 million from operations in fiscal 2008. The sale of Jenkins resulted in a fiscal 2008 impairment charge of $6.3 million.

Other key components of the system include a cancer center in Norton Va., an assisted-living and adult day care center; a hospice; a wellness and fitness center; a fundraising foundation; and a number of relatively small for-profit subsidiaries, including a physician-hospital organization, a billing-and-collection service, two retail pharmacies, and a regional laundry.

The system currently consists of eight hospitals with about 1,286 licensed beds serving Tennessee and Virginia markets. Wellmont's primary service area (PSA) encompasses three Tennessee counties and six Virginia counties. The system's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, are both in Tennessee but are very close to the Virginia border. Portions of Bristol's facility are across the border in Virginia. The Virginia side of the service area is more rural and has a lower population density than the Tennessee side but also less competition. Even though Wellmont has no hospitals located in some of its PSA counties that are in Virginia, the system draws sizable market share from those counties. For example, market share in Scott County, Va. is 68%. In its core county of Sullivan, Tenn., there are three hospitals: Bristol, Holston Valley, and Mountain State's Indian Path Medical Center. Wellmont draws a solid 59% market share in Sullivan County, while Mountain States Health Alliance (MSHA) garners a 36% market share. Overall, market share for the nine PSA counties is solid at 56% and continues to grow. County-by-county market share ranges from 28% to 85%.

Bristol Regional Medical Center was a brand-new hospital in 1994 and is an attractive facility with a sizable campus and a broad range of services. Holston Valley Medical Center is the core tertiary provider in the primary service area, with a very active cardiac program, a level-one trauma center, a neonatal program, and other programs typical of a tertiary center. Both hospitals should benefit from the "Project Platinum" expansion and renovation plans funded with series 2006C bond proceeds.

Although MSHA and Wellmont have historically been fiercely competitive, both have benefitted from regional population growth. With the change in leadership at Wellmont over the past year, there appears to be a desire for a more collaborative working relationship between the two systems.

Finances: Improved Financial Metrics

For the fiscal year ended June 30, 2009 (unaudited), Wellmont generated operating income of $6.5 million (a 0.87% margin) on $739 million of total net revenues. Operating results reflect an $11.1 million positive swing from fiscal 2008, although 2008 was negatively affected by a $6.3 million impairment charge related to the April 30, 2009 sale of Jenkins Community Hospital. Net operating income improved from Wellmont's implementation of revenue and expense cycle initiatives, which generated $7.5 million of incremental income for fiscal 2009, and are expected to produce $15 million of operational improvements in 2010. Wellmont's 2010 budgeted operating income is $19.8 million.

Acute discharges were up slightly to 42,558 relative to fiscal 2008 inpatient volumes of 42,401. Combined inpatient and outpatient surgery volumes grew by 3.9% to 25,128. Emergency department visits declined 2% to 222,560 from 227,181 in 2008.

Wellmont's excess revenues, as per Standard & Poor's calculations, were $10.3 million, which included $8.4 million of realized investment income offset by discontinued operations and other nonoperating expenses. While positive, investment income was well short of budget and substantially below 2008 when Wellmont's investments generated realized income of $31.6 million. Unrealized investment losses in fiscal 2009 were $65 million. Wellmont also had a $5.7 million unrealized loss on its swaps at year-end. Both unrealized investment and swap losses are treated as below the line for purposes of Standard & Poor's analysis.

Cash flow remains acceptable as evidenced by a 9% EBIDA margin, generating 2.2x coverage of Wellmont's $30.6 million maximum debt service. Historically operating leases have been relatively modest in amount. However, as

Wellmont monetizes its medical office buildings, operating leases have become more material to its overall financial profile. Adjusted for the growing operating lease expense, MADS coverage is diluted by 0.42x to 1.8x .

Wellmont's balance sheet remains acceptable, although due to the decline in capitalization over the past couple of years, leverage metrics are now at a level where the system has very limited flexibility to issue more debt without a rating implication. However, there are currently no plans to issue new debt, and Wellmont has $37 million of unspent series 2006C bond proceeds. which is adequate to complete its "Project Platinum," which includes a new surgical suite, intensive care unit, and emergency department projects that are currently underway at Holston Valley Medical Center.

Unrestricted cash and investments totaled $248.8 million at year-end, equal to 131 days' cash on hand, and 54% of long-term debt. Cash was flat relative to last year. Wellmont's long-term debt to capitalization increased to 58%, from 54% in 2008, although the increase was strictly a function of a smaller denominator. Other than information-technology-related capital spending, Wellmont has limited capital spending plans that should support the continued growth of unrestricted cash and investments. The system's 2010 budget reflects an 18-day increase in day's cash on hand to 149 days, and 62% cash to debt.

About 85% of the system's cash and investment assets are liquid with maturities of less than one year. Less than 10% ($23.2 million) are invested in real assets and private equity. Wellmont has a moderate level of future private equity capital funding commitments equal to $15 million.

Debt Derivative Profile: '3.0'

Wellmont's overall DDP score has been revised to '3.0' on a scale of '1' to '4', whereby '1' represents the lowest risk and '4' is the highest. The overall score of '3.0' reflects Standard & Poor's view that Wellmont's swap exposure represents a moderate credit risk at this time.

The overall score of '3.0' includes the following factors:

- Above-average collateral posting risk due to the requirement that Wellmont post collateral when its rating falls to 'BBB-' or lower, a somewhat narrow spread for a 'BBB+' credit (there are no termination-rating triggers);
- High counterparty risk, based on the credit quality of the counterparty, Lehman Brothers Special Financing, guaranteed by Lehman Brothers Holdings (not rated), which filed for bankruptcy in September 2008;
- Low economic viability risk based on projected performance under stressful economic scenarios; and
- Strong management practices, including a written swap policy, thorough audit disclosure, frequent communication of swap performance to the board, and the use of independent financial advisors to assist in evaluating swap strategies and performance.

Wellmont has four swaps in place, all of which are with Lehman Brothers Special Financing. The swaps include a $66.3 million notional basis swap that matures in 2032, under which Wellmont pays the Securities Industry and Financial Markets Municipal Assn. (SIFMA) swap index rate and receives 73.8% of LIBOR. In 2006, Wellmont executed a total return swap related to its series 2006A bonds, which it placed were privately. Under the total return structure, Wellmont synthetically converted its cost on the bonds to the SIFMA index rate plus 85 basis points from the index rate. The remaining two swaps synthetically fix $99.3 million of variable-rate debt. They are traditional floating- to fixed-rate swaps using one-month LIBOR as the receive index. Variable-rate debt is 30.9% of the total,

but inclusive of the effects of the swaps, Wellmont's current net variable-rate exposure is 9.1%.

Related Research

- USPF Criteria: "Not-For-Profit Health Care," June 14, 2007
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- USPF Criteria: "Debt Derivative Profile Scores," March 27, 2006

STANDARD &POOR'S

Global Credit Portal
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February 19, 2010

Sullivan County Health, Educational, and Housing Facilities Board, Tennessee
Wellmont Health System; System

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Sullivan County Health, Educational, and Housing Facilities Board, Tennessee Wellmont Health System; System

Credit Profile		
Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)		
Long Term Rating	BBB+/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on bonds issued for Wellmont Health System, Tenn. by various issuers. The outlook is stable.

The rating affirmations and stable outlook reflect improved operating and financial metrics following management's implementation last year of various expense and revenue cycle improvements, which it expects to support Wellmont's improved performance on an ongoing basis.

More specifically the ratings reflect Wellmont's:

- Stronger financial metrics, including positive fiscal 2009 operating income of $6.5 million (a 0.88% margin) and six-month year-to-date operating income of $15.2 million as of Dec. 31;
- Acceptable 2.1x fiscal year-end maximum annual debt service (MADS) coverage (or 1.7x on an operating lease-adjusted basis), which remained consistent with prior years, despite the significant decline of investment income and other nonoperating revenues in fiscal 2009;
- Stabilized, although still constrained, balance sheet due to its acquisition activity over the past five years. Current (Dec. 31) balance sheet metrics are characterized by 146 days' cash on hand, a moderately high 56% long-term debt to total capitalization, and unrestricted cash to long-term debt of 55%; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings are revenue cycle, staffing, expense, and other operating improvements that generated $7.5 million of incremental operating income for fiscal 2009 and are expected to produce about $15 million in improvements for fiscal 2010. Additionally, accounting issues leading to the delayed release of the system's fiscal 2008 audit and the restatement of fiscal 2007 results have been resolved.

Wellmont recently hired a permanent CFO, Beth Ward, who was formerly CFO of Moses Cone Health System in Greensboro N.C. Also, Mike Snow, Wellmont's CEO, announced his resignation effective March 1, 2010. Bob Burgin, who serves on Wellmont's board and who had previously retired as Mission Health's (Asheville, N.C.) president and CEO in 2004, will take over as interim CEO for Wellmont while a search is conducted for his permanent replacement. During his tenure as interim CEO, Mr. Burgin has taken a leave of absence from Wellmont's board.

As of June 30, 2009, Wellmont had $452.2 million of bonded debt. A gross revenue pledge of the obligated group and a mortgage on Wellmont's two largest hospitals, Lee Regional Hospital, and Mountain View Hospital secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, and three recently acquired hospitals. All of the system's entities are included for the purpose of our calculations in this report.

Wellmont's direct-pay letter of credit agreement with Bank of America N.A. (BofA) expires in December 2010. Management expects to reach a successful extension with BofA, but should an agreement not be reached, the level of puttable debt relative to unrestricted cash is manageable at about 26%. The system is currently in compliance with its bank and bond covenants.

Wellmont's overall Debt Derivative Profile (DDP) score is '3' on a scale of '1' to '4', with '1' representing the lowest risk. The overall score of '3' reflects Standard & Poor's view that the risks associated with Wellmont's derivatives portfolio are moderate at this time due to risks associated with the Lehman bankruptcy. As of Dec. 31, Wellmont's swap liability was $7.7 million. There is no required collateral posting at this time. Additionally there have been no changes to Wellmont's swap portfolio since our last published report on Aug, 24, 2009.

Outlook

The stable outlook reflects our increased comfort that Wellmont has corrected the accounting issues that led to the restated fiscal 2007 results and the fiscal 2008 audit delay. Additionally, while reimbursement, competitive issues, or other factors may constrain Wellmont's operations in the future, we believe that management's initiatives to reduce costs and improve the revenue cycle will support a generally improving operating trend over the outlook period. In addition, we believe that as market conditions continue to improve, Wellmont's liquidity metrics and cash flow coverage will likewise improve. While we remain focused on certain credit weaknesses, including leverage, we understand that Wellmont's future capital spending plans are modest and management has no current plans to issue additional long-term debt. Should the balance sheet or operations unexpectedly weaken, a downgrade or the return to a negative outlook would be likely. By contrast, significant improvement to the balance sheet over time would be cause for a positive outlook revision and possibly an upgrade.

Finances

For the fiscal year ended June 30, 2009, Wellmont generated operating income of $6.5 million (a 0.88% margin) on $737 million of total net revenues. Operating results reflect an $11.1 million positive swing from fiscal 2008, although 2008 was negatively affected by a $6.3 million impairment charge related to the April 30, 2009, sale of Jenkins Community Hospital. Net operating income improved from Wellmont's implementation of revenue and expense cycle initiatives, which generated $7.5 million of incremental income for fiscal 2009, and are expected to produce $15 million of operational improvements in fiscal 2010. Wellmont's fiscal 2010 budgeted operating income is $19.8 million.

Acute discharges rose slightly to 42,558 in fiscal 2009 from 42,401 in fiscal 2008. Combined inpatient and outpatient surgery volumes grew by 3.9% to 25,128. Emergency department visits declined 2% to 222,560 from

227,181 in fiscal 2008.

Wellmont's excess revenues, as per Standard & Poor's calculations, were $6.1 million, which included $8.8 million of realized investment income offset by discontinued operations and other nonoperating expenses. While positive, investment income was well short of budget and substantially below fiscal 2008's $31.6 million. Unrealized investment losses in fiscal 2009 were $60 million. Wellmont also had a $5.7 million unrealized loss on its swaps at year-end. Both unrealized investment and swap losses are treated as below the line for purposes of Standard & Poor's analysis.

Cash flow remains acceptable as evidenced by a 9% EBIDA margin, generating 2.1x coverage of Wellmont's $30.6 million MADS. Historically operating leases have been relatively modest in amount. However, as Wellmont monetizes its medical office buildings, operating leases have become more material to its overall financial profile. Adjusted for the growing operating lease expense, MADS coverage is diluted to 1.7x.

Wellmont's balance sheet remains acceptable, although due to the decline in capitalization over the past couple of years, leverage metrics are now at a level where the system has very limited flexibility to issue more debt without a rating implication. Wellmont recently completed its "Project Platinum," which includes a new surgical suite, intensive care unit, and emergency department project at Holston Valley Medical Center. We understand that management currently no plans to issue new debt.

Unrestricted cash and investments totaled $250.3 million at year-end, equal to 133 days' cash on hand and 50% of long-term debt. Cash was flat relative to last year. Wellmont's long-term debt to capitalization rose to 60% from 55% in 2008, although the increase was strictly a function of a smaller denominator. Other than information-technology-related capital spending, Wellmont has limited capital spending plans that should support the continued growth of unrestricted cash and investments.

About 85% of the system's cash and investment assets are liquid with maturities of less than one year. Less than 10% ($23.2 million) are invested in real assets and private equity. Wellmont has a moderate level of future private equity capital funding commitments equal to $15 million.

Interim Financial Metrics

Through the first six months ended Dec. 31, 2009, Wellmont generated $15.2 million of operating income (a 4.1% margin) on $374.4 million of total operating revenues. Operations compared favorably with Wellmont's $5.2 million loss for the first six months of last year. Excess income was $19.8 million (a 5.2% margin) compared with an excess loss of $627,000 in 2009, as per Standard & Poor's calculations, which treat unrealized derivative valuation adjustments as below the line items. Same-facility patient volumes were flat relative to the prior year. Management attributes improved fiscal 2010 operating performance to revenue and expense cycle initiatives implemented in late fiscal 2009.

Unrestricted cash and investments grew to $270 million by Dec. 31, equal to 146 days of operating expenses and 55% of Wellmont's total debt outstanding. The system's debt to capitalization improved to 56%. All figures are based on Standard & Poor's calculations.

Debt Derivative Profile: '3'

Wellmont's overall DDP score has been revised to '3' on a scale of '1' to '4', whereby '1' represents the lowest risk. The overall score of '3' reflects Standard & Poor's view that Wellmont's swap exposure represents a moderate credit risk at this time.

The overall score of '3.0' includes the following factors:

- Above-average collateral posting risk due to the requirement that Wellmont post collateral when its rating falls to 'BBB-' or lower, a somewhat narrow spread for a 'BBB+' credit (there are no termination-rating triggers);
- High counterparty risk, based on the credit quality of the counterparty, Lehman Brothers Special Financing, guaranteed by Lehman Brothers Holdings (not rated), which filed for bankruptcy in September 2008;
- Low economic viability risk based on projected performance under stressful economic scenarios; and
- Strong management practices, including a written swap policy, thorough audit disclosure, regular communication of swap performance to the board and investors, and the use of independent financial advisors to assist in evaluating swap strategies and performance.

Wellmont has four swaps in place, all of which are with Lehman Brothers Special Financing. At Dec. 31 the swaps had a combined marked to market value of negative $7.7 million. At that level of swap liability, no collateral posting is required. Variable-rate debt is about 31% of the total, but inclusive of the effects of the swaps, Wellmont's current net variable-rate exposure is about 9.0%.

Related Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- USPF Criteria: Debt Derivative Profile Scores, March 27, 2006
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009

Ratings Detail (As Of February 19, 2010)		
Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)		
Unenhanced Rating	BBB+(SPUR)/Stable	Affirmed
Virginia Small Business Fin Auth, Virginia		
Wellmont Hlth Sys, Tennessee		
Virginia Small Business Fin Auth (Wellmont Health System)		
Long Term Rating	BBB+/Stable	Affirmed

Many issues are enhanced by bond insurance.

STANDARD &POOR'S

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April 29, 2011

Sullivan County Health, Educational, and Housing Facilities Board, Tennessee Wellmont Health System; System

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Sullivan County Health, Educational, and Housing Facilities Board, Tennessee Wellmont Health System; System

Credit Profile		
US$76.265 mil hosp rev rfdg bnds (Wellmont Hlth Sys) ser 2011 dtd 05/03/2011 due 09/01/2032		
Long Term Rating	BBB+/Stable	New
Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)		
Long Term Rating	BBB+/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services assigned its 'BBB+' long-term rating to Sullivan County Health, Educational, and Housing Facilities Board, Tenn.'s $76.2 million series 2011 fixed-rate refunding bonds issued for Wellmont Health System. At the same time, Standard & Poor's affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on Wellmont's other rated bonds from various issuers. Standard & Poor's expects to assign an 'A-1+' short-term rating to Wellmont's series 2005 bonds based on the support of JP Morgan Chase Bank N.A. (AA-/A-1+), the replacement letter of credit provider. The outlook is stable.

The series 2011 bonds will fully refund Wellmont's series 2006A variable-rate obligations outstanding (not rated) with fixed-rate debt of the same maturity. For the series 2005 variable-rate demand bonds (not rated), Wellmont plans to obtain a replacement direct-pay letter of credit from JP Morgan Chase. The letter of credit is currently provided by Bank of America.

The ratings and stable outlook reflect our view of improved operating and financial metrics following management's implementation in 2009 of various expense and revenue cycle initiatives, which it expects to support Wellmont's improved performance on a sustained basis.

More specifically, the ratings reflect our opinion of Wellmont's:

- Solid financial metrics, including positive fiscal 2010 operating income of $22.8 million (a 3.2% margin) and six-month year-to-date operating income of $4.4 million as of December 31;
- Acceptable 2.8x fiscal year-end maximum annual debt service (MADS) coverage (or 2.1x on an operating lease-adjusted basis), which improved from prior years;
- Improved, although still constrained balance sheet due to its acquisition activity over the past several years. As of December 31, Wellmont had 193 days' cash on hand, moderately high 53% long-term debt to total capitalization, and unrestricted cash to long-term debt of 80%; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings is our view of revenue cycle, staffing, expense, and other operating improvements that

helped Wellmont generate net operating income of $7.0 million in fiscal 2009 (a $4.7 million improvement over fiscal 2008) and an operating profit of $22.8 million in fiscal 2010. In addition, the system's major acquisition activities are completed, which will likely allow Wellmont to continue to build balance sheet strength.

In June 2010, Wellmont named Margaret "Denny" DeNarvaez president and CEO of the health system. She assumed the role in August 2010 from Bob Burgin, who served as Wellmont's interim CEO following the resignation of Mike Snow in March. Ms. DeNarvaez joined Wellmont from St. John's Mercy Healthcare in St. Louis, where she served as its CEO.

As of June 30, 2010, Wellmont had $447 million of bonded debt. Gross revenues of the obligated group and a mortgage on Wellmont's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, as well as two of its community hospitals, Lee Regional Medical Center and Mountain View Regional Medical Center, secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system's hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Lee Regional Medical Center, and Mountain View Regional Medical Center. All of the system's entities are included for the purpose of our calculations in this report.

Wellmont's direct-pay letter of credit agreement with Bank of America N.A. expires on July 1, 2011. As noted above, management plans to obtain a replacement letter of credit for its series 2005 variable-rate demand bonds from JP Morgan Chase. The level of puttable debt relative to unrestricted cash as of Dec. 31, 2010, is manageable, in our view, at about 16%. The system is currently in compliance with all bank and bond covenants.

Wellmont's overall Debt Derivative Profile (DDP) score is '3' on a scale of '1' to '4', with '1' representing the lowest risk. The overall score of '3' reflects Standard & Poor's view that the risks associated with Wellmont's derivatives portfolio are moderate at this time due to risks associated with the Lehman bankruptcy. As of March 31, 2011, Wellmont's swap liability was $10.0 million. There is no required collateral posting at this time. In addition, there have been no changes to Wellmont's swap portfolio since our last published report on Feb. 19, 2010.

Outlook

The stable outlook reflects our view of management's initiatives to reduce costs and improve the revenue cycle. While we remain focused on certain credit weaknesses, including leverage, we understand that Wellmont's future capital spending plans are modest and that management has no current plans to issue additional long-term debt. Should the balance sheet or operations unexpectedly weaken, a downgrade or a negative outlook would become more likely. By contrast, significant improvement to the balance sheet over time, provided good operating performance is sustained, could be cause for a positive outlook revision and possibly an upgrade.

Finances

For the fiscal year ended June 30, 2010, Wellmont generated operating income of $22.8 million (a 3.2% margin) on $724 million of total net revenues. Operating results reflect a $15.8 million improvement over fiscal 2009. Net operating income has materially improved over the past two years, principally due to Wellmont's implementation of revenue and expense cycle initiatives. Wellmont's fiscal 2011 budgeted operating income was $24 million; however, operating results are more likely to be about half that amount, resulting in an operating margin of about 1.5%

(down from more than 3% last year). Wellmont attributes this year's decline mainly to weather-related volume decreases at its Virginia hospitals: due to harsh winter weather conditions, volumes in those hospitals declined by 6% to 10% and patient no-show rates exceeded 50%.

Acute discharges dipped 2.8% to 41,380 in fiscal 2010 from 42,558 in fiscal 2009, although with observation patients included, those patient volumes increased by 0.5% to 50,910 in fiscal 2010. Combined inpatient and outpatient surgery volumes declined by 6.0% to 36,559 while emergency department visits decreased 4.6% to 212,383 from 222,560 in fiscal 2009. According to management, those declines were attributed to economic weakness but also transportation problems due to winter weather conditions in 2010.

For the fiscal year, Wellmont's excess revenues, as per Standard & Poor's calculations, were $20.8 million, which included $1.0 million of realized investment income offset by discontinued operations and other nonoperating expenses. While positive, investment income was substantially lower than two previous fiscal years; however, unrealized investment gains in fiscal 2010 were $22.3 million, compared to more than $60 million of unrealized losses in 2009. Wellmont also had a $2.7 million unrealized loss on its swaps at year-end. Both unrealized investment gains and the swap loss are treated as below the line for purposes of Standard & Poor's analysis.

Cash flow remains acceptable, in our view, as evidenced by an 11.7% EBIDA margin, generating 2.8x coverage of Wellmont's $30.6 million MADS. Operating leases have historically been relatively modest in amount. However, as Wellmont monetizes its medical office buildings, operating leases have become more material to its overall financial profile. Adjusted for the growing operating lease expense, MADS coverage is diluted to 2.1x.

Wellmont's balance sheet remains acceptable, in our opinion, although due to the decline in capitalization over the past few years, leverage metrics are now at a level where the system has very limited flexibility to issue more debt at the current rating level. However, we understand that management has no current plans to issue any additional debt, other than for refunding purposes.

Unrestricted cash and investments totaled $316 million at year-end, equal to 175 days' cash on hand and 64% of long-term debt, as per Standard & Poor's calculation methodology. Wellmont excludes the less liquid investments from the days' cash calculation, resulting in 156 days' cash at the fiscal year-end, compared with its minimum covenant level of 100 days. Robust cash flow and minimal capital spending needs allowed cash to grow by more than $65 million relative to last year. Other than modest strategic, information technology, and equipment-related capital spending, Wellmont has limited spending plans that will likely support the continued growth of the system's liquidity.

About 85% of the system's cash and investment assets are liquid with maturities of less than one year. Less than 10% ($23.5 million) are invested in real assets and private equity. Wellmont has a moderate level of future private equity capital funding commitments equal to $12 million.

Interim Financial Metrics

Through the six months ended Dec. 31, 2010, Wellmont generated $4.4 million of operating income (a 1.1% margin) on $390 million of total operating revenues despite an increase in patient volumes. Operations compared unfavorably with Wellmont's $15 million in operating revenue for last year principally due to expense increases related to drug costs, higher personnel, and other expenses and interest expense and depreciation associated with the

completion of Project Platinum. Excess income for the six months was $10.7 million (a 2.7% margin), down from $19.8 million (a 5.2% margin) for the same period in fiscal 2010.

Unrestricted cash and investments grew to $383 million by December 31, equal to 193 days of operating expenses and 80% of Wellmont's total debt outstanding. The system's debt to capitalization improved to 53%. All figures are based on Standard & Poor's calculations.

Debt Derivative Profile

Wellmont's overall DDP score has been revised to '3' on a scale of '1' to '4', whereby '1' represents the lowest risk. The overall score of '3' reflects Standard & Poor's view that Wellmont's swap exposure represents a moderate credit risk at this time.

The overall score of '3.0' reflects our view of:

- Above-average collateral posting risk due to the requirement that Wellmont post collateral when its bond rating falls to 'BBB-' or lower, a somewhat narrow spread for a 'BBB+' credit (there are no termination-rating triggers);
- High counterparty risk, based on the credit quality of the counterparty, Lehman Brothers Special Financing, guaranteed by Lehman Brothers Holdings (not rated), which filed for bankruptcy in September 2008;
- Low economic viability risk based on projected performance under stressful economic scenarios; and
- Strong management practices, including a written swap policy, thorough audit disclosure, regular communication of swap performance to the board and investors, and the use of independent financial advisors to assist in evaluating swap strategies and performance.

Wellmont has four swaps in place, all of which are with Lehman Brothers Special Financing. At March 31, 2011, the swaps had a combined mark-to-market value of negative $10 million. At that level of swap liability, no collateral posting is required. Variable-rate debt is about 34% of the total, but inclusive of the effects of the swaps, Wellmont's current net variable-rate exposure is about 15%

Related Criteria And Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- USPF Criteria: Debt Derivative Profile Scores, March 27, 2006

Ratings Detail (As Of April 29, 2011)

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Sullivan Cnty Hlth Ed & Hsg Fac Brd (Wellmont Health System)		
Unenhanced Rating	BBB+(SPUR)/Stable	Affirmed
Virginia Small Business Fin Auth, Virginia		
Wellmont Hlth Sys, Tennessee		
Virginia Small Business Fin Auth (Wellmont Health System)		
Long Term Rating	BBB+/Stable	Affirmed

Many issues are enhanced by bond insurance.

FITCH RATES WELLMONT HEALTH SYSTEM, TN'S 2011 REVS 'BBB+'; OUTLOOK STABLE

Fitch Ratings-New York-02 May 2011: Fitch Ratings assigns a 'BBB+' rating to the expected issuance of approximately $76 million of Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee hospital revenue refunding bonds (Wellmont Health System Project), series 2011, issued on behalf of Wellmont Health System (Wellmont).

In addition, Fitch affirms the 'BBB+' rating on the following bonds:

--$76,595,000 revenue refunding bonds, series 2006A;
--$200,000,000 hospital revenue bonds, series 2006C;
--$59,580,000 hospital revenue refunding bonds, series 2005;
--$36,665,000 hospital revenue refunding bonds, series 2003;
--$55,000,000 Virginia Small Business Financing Authority hospital revenue bonds, series 2007A.

The Rating Outlook is Stable.

Proceeds from the 2011 fixed rate bonds will be used to refinance the series 2006A bonds. In March 2011, Wellmont put out a tender notice for the 2006A bonds, which was accepted by all outstanding bondholders. The 2006A bonds were variable rate index bonds and redeemable in whole at any time. After issuance, Wellmont's long-term debt will total $457.4 million, which includes a $30 million variable-rate, bank qualified loan secured in 2010. After replacing the 2006A variable-rate bonds, Wellmont's debt structure will be comprised of 80% of fixed rate bonds, a relatively conservative debt portfolio. The 2011 bonds will be sold the week of May 4th.

RATING RATIONALE:
--Most of Wellmont's financial and capital metrics are consistent with the rating category.
--Wellmont benefits from a leading inpatient market share of 60% (2009) in its primary service area and a stable market share in its secondary markets.
--Operating margins are expected to be approximately 1.5% over the next few years as a new CEO and new senior management team implement strategic initiatives around quality, information technology, and physician alignment.
--Six month fiscal 2011 interim figures show an operating margin of 1.1%, which supports solid pro forma maximum annual debt service (MADS) coverage of 2.6 times (x).
--With no new debt issuance expected over the next two to three years, Fitch expects Wellmont's elevated leverage indicators to moderate.

KEY RATING DRIVERS
--A new senior management team implements its strategy over the medium term, bringing a measure of stability at the senior management level that has eluded Wellmont over the last few years and has been a credit concern.
--In spite of the strategic investments, Wellmont is able to maintain its current level of operations keeping its financial profile relatively stable.

SECURITY
Bonds are secured by gross receipts and mortgage pledge of the obligated group (OG). A fully funded debt service fund and a liquidity covenant provide additional security. For the fiscal year ended June 30, 2010, the OG accounted for 89.4% of the system's total net assets, 87.6% of its operating revenues and 64.7% of its operating income.

CREDIT SUMMARY
The 'BBB+' rating is supported Wellmont's overall financial profile that is consistent with most rating category medians and its leading inpatient market share in its primary service area (PSA).

Credit concerns include the continued turnover in senior management and a slightly elevated debt burden.

Wellmont finished fiscal 2010 (year end June 2010) with a 3.1% operating margin and pro forma MADS coverage of 2.5x, both solid for the 'BBB' category. Six-month interim results show an operating margin of 1.1% and MADS coverage of 2.6x. The lower operating margin is more in line with where Fitch expects Wellmont's operations to be over the next few years, given softer volumes and expenses related to strategic initiatives of the new management team. The former management team was more focused on expense management and efficiency, which contributed to the higher operating margin in fiscal 2010.

Senior management turnover at Wellmont has been a credit concern over the past few years; the new CEO has been in place nine months and has added new members to the management team. A key rating driver for Wellmont is maintaining stability at the senior management level, especially as the management team pursues critical strategic initiatives around quality, information technology, and physician alignment.

Liquidity is good for the rating category. As of Dec. 31, 2010, Wellmont had cash and unrestricted investments of $315.5 million (adjusted for $14 million line of credit), which equated to days cash on hand (DCOH) of 167.4, a cushion ratio of 9.2x, and cash to debt of 69.2%. DCOH and the cushion ratio were above their respective category medians, while cash to debt was below. In January 2011, Wellmont paid down $7 million of the line of credit.

Wellmont's debt burden remains elevated for the rating level, as represented by MADS as a percentage of revenue of 4.4%, Debt-to-EBITDA of 5.1x, and debt to capitalization of 56.6% as of Dec. 31, 2010, all of which are above the category medians. Mitigating this concern is the expectation that Wellmont will be issuing no new debt over the next two to three years, which should help ease some of these ratios.

The Stable Outlook reflects Fitch's belief that Wellmont will maintain its current level of operating performance, which should continue to support solid debt service coverage. The service area remains fairly competitive with Mountain States Health Alliance (general revenue bonds rated 'BBB+' by Fitch) a formidable competitor. However, the competitive pressures have subsided in the past few years, and Wellmont's leading 60% market share in its PSA has been stable. Capital expenditures over the next two to three years are expected to be reasonable at approximately $45 to $50 million per year (representing just over 100% of depreciation). The biggest short-term outlay will be $14 million for information technology. Wellmont expects to be ready for meaningful use within the next 18 months.

Wellmont has four swaps in place. Lehman is the counterparty for all the swaps and there are no collateral posting requirements at the current rating level. The aggregate mark to market as of March 31, 2011 was a negative $10 million.

Wellmont Health System (WHS) is a large regional health care system with eight acute hospitals (856 staffed beds) and other related entities located in northeastern TN and southwestern VA. Wellmont had approximately $724.4 million in total revenue in fiscal 2010. WHS covenants to provide audited financial statements to the Municipal Securities Rulemaking Board's Electronic Municipal Market Access system (EMMA), as well as quarterly unaudited statements.

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Additional information is available at 'www.fitchratings.com'.

Applicable Criteria and Related Research:
--'Revenue-Supported Rating Criteria', dated Oct. 10, 2010;
--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Dec. 29, 2009.

For information on Build America Bonds, visit 'www.fitchratings.com/BABs'.

Applicable Criteria and Related Research:
Revenue-Supported Rating Criteria
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=564565
Nonprofit Hospitals and Health Systems Rating Criteria
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=493186

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Table Of Contents

Sullivan County Health Educational & Housing Facilities Board, Tennessee
Wellmont Health System; System

Credit Profile		
Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Ser 2006C		
Long Term Rating	BBB+/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on $360.4 million in bonds, including series 2003, 2006C, 2007A, and 2011, issued for Wellmont Health System, Tenn. by various issuing authorities. The outlook is stable.

In addition, Standard & Poor's 'AA-/A-1+' long-term and short-term ratings on Wellmont's $54.8 million series 2005 variable-rate demand obligations are based solely on the support of JP Morgan Chase Bank N.A. (AA-/A-1+), the letter of credit provider.

The affirmed ratings and stable outlook reflect our view of Wellmont's improving operating and financial metrics as well as its stable enterprise profile. We believe that Wellmont is well positioned for operational success with respect to its markets, competition, and changing reimbursement environment.

More specifically, the ratings reflect our opinion of Wellmont's:

- Solid financial metrics, including positive fiscal 2012 unaudited operating income of $20.7 million (a 2.6% margin), as per Standard & Poor's calculations;
- Acceptable 3.0x fiscal year end maximum annual debt service (MADS) coverage, which continues to improve from prior years;
- Improved balance sheet highlighted by the system's 192 days' cash on hand, moderately elevated 50% long-term debt to total capitalization, and unrestricted cash to long-term debt of 83%, as per Standard & Poor's calculations; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings is our view of revenue cycle, staffing, expense, and other operating improvements that have helped Wellmont generate consistently robust operating results during the past three fiscal years. In addition, we anticipate that as the system's major acquisition activities are completed, Wellmont will likely be able to continue to build balance sheet strength over time.

Partially offsetting the above-noted strengths, in our opinion, is Wellmont's plan to issue roughly $55 million of new

debt in fiscal 2013, as well as management's plan to transition the health system over to an Epic IT Platform, which during the next five years will involve about $100 million of capital spending. While the transition to Epic could potentially involve some disruption to Wellmont's operations, management believes that it is very well prepared to undertake the implementation and had a very successful recent implementation of its electronic health record.

In addition, while we believe that major facilities acquisitions are done now that most of the desirable candidates in the markets served by Wellmont and its major competitor have been acquired, we continue to believe that competition for patient volumes between these two sizable systems remains intense.

As of June 30, 2012, Wellmont had $459 million of bonded debt and capital leases. About $82 million of Wellmont's outstanding debt is variable-rate obligations, including $24.8 million in bank qualified directly placed index floating-rate bonds (not rated). The variable-rate obligations have tender provisions that may allow the bonds to be redeemed before maturity. In our opinion, the amount of puttable debt relative to unrestricted cash as of June 30, 2012 is manageable, at about 17%. In addition, Wellmont has more than adequate unrestricted liquidity available to cover these potential tender obligations by a ratio of 4.6x. We understand that Wellmont may issue approximately $55 million of incremental debt in fiscal 2013, and, in our opinion, the system has capacity to issue some additional debt, including the amount contemplated, without negatively affecting the ratings.

Wellmont uses interest rate swaps to partially hedge its interest rate risk. Wellmont has three swaps totaling $161 million notional principal; Lehman Brothers Special Financing is the counterparty. In our opinion, the risks associated with Wellmont's derivatives portfolio are moderate at this time. As of June 30, 2012, Wellmont's swap liability was $16.7 million and there is no required collateral posting. In addition, there were no changes to Wellmont's swap portfolio since our last published report on April 29, 2011.

The system remains in compliance with all bank and bond covenants. Gross revenues of the obligated group and a mortgage on Wellmont's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, as well as two of its community hospitals, Lee Regional Medical Center and Mountain View Regional Medical Center, secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system's hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Lee Regional Medical Center, and Mountain View Regional Medical Center. All of the system's entities are included for the purpose of our calculations in this report.

Outlook

The stable outlook reflects our view of management's initiatives to control expenses and increase incremental revenues through its ambulatory strategy and oncology and cardiology service line focus. We anticipate that balance sheet metrics will likely remain stable or improve during the two-year outlook period as most of Wellmont's major bricks-and-mortar capital spending initiatives have been completed -- although the system's transition to Epic for its clinical information system will represent a sizable level of spending during the next five years. We are aware that Wellmont plans to issue about $55 million of new debt in fiscal 2013 and while the details are uncertain at this time,

the system maintains adequate capacity to support this level of incremental debt at the existing rating level, in our opinion.

Should the system's balance sheet or its operations unexpectedly weaken, such that Wellmont's MADS coverage declines and is sustained below 2.0x, or if unrestricted liquidity falls to fewer than 150 days or 70% of long-term debt, then a downgrade or a negative outlook would become more likely. By contrast, improvement to the balance sheet over time, provided operating performance remains good, could be cause for a positive outlook revision and possibly an upgrade.

Enterprise Profile

Wellmont is an eight-hospital system headquartered in Kingsport, Tenn. and is composed of 1,253 licensed (856 staffed including managed (not owned acute), psych, rehab, and skilled nursing facility) inpatient beds. The system's facilities are located in Tennessee and Virginia. Acute discharges totaled 40,121 in fiscal 2012, down 4.6% from fiscal 2011. Total bedded volumes, including observations, increased to 53,790, or by 1.7%, compared with the previous fiscal year. The system's outpatient registrations continue to grow, and totaled 236,437 in fiscal 2012, up 5.1% from fiscal 2011, partially driven by the system's acquisition of a cardiology practice earlier this year. Emergency department and combined surgery volumes were essentially flat.

Management remains focused on the system's ambulatory strategy, which includes the creation of a strategic infrastructure around oncology and cardiology centers of excellence. Pulmonology is also a service line that management considers a strategic focus. Although in the past several years Wellmont had been focused on the acquisition of hospitals and facilities, both in Tennessee and in Virginia, major facilities acquisition activity is completed as there are few desirable remaining hospital acquisition candidates in the system's service area that are not already affiliated with Wellmont or its major competitor. Management's current strategy is to maintain or develop outposts to draw patients from a larger geographic area without having to have a hospital located in those areas. In addition, management plans to capitalize on its strengths in core service lines supported by its new dyad leadership model, which appears to be creating favorable results through improved patient satisfaction scores.

Management

Wellmont named Alice Pope CFO of Wellmont in August 2012. Ms. Pope previously served as SVP finance managed care and revenue cycle for the system, and has served in various roles with the organization during the past 12 years.

Financial Profile

For the fiscal year ended June 30, 2012 (unaudited), Wellmont generated operating income of $20.7 million (a 2.6% margin) on $789.7 million of total net revenues. Commencing with these fiscal 2012 results, and this review, Standard & Poor's analysis conforms to accounting rule ASU 2011-07, which changes the classification of bad debt expense to a deduction from revenues. This change had the effect of elevating days' cash on hand and reflecting modestly higher operating and excess margins.

Operating results reflect a $4.8 million improvement over fiscal 2011 principally due to Wellmont's implementation of revenue and expense cycle initiatives, including a narrow network agreement with Cigna for a major local employer and physician practice acquisitions, as well as a greater focus on documentation and coding, increasing its case mix, and reducing lengths of stay.

For the fiscal year, Wellmont's excess revenues, as per Standard & Poor's calculations, were $38 million (or a 4.7% margin), which included $17.3 million of realized investment income. Wellmont also had a $5.1 million unrealized loss on its swaps at year end, and unrealized investment losses of $9.5 million. Both unrealized investment losses and the swap loss are treated as below the line for purposes of Standard & Poor's analysis.

Cash flow remains acceptable, in our view, as evidenced by a 13.2% EBIDA margin, generating just over 3.0x coverage of Wellmont's $35.2 million MADS. Operating leases have historically been relatively modest in amount; however, with the monetization of Wellmont's medical office buildings, operating leases have become more material to the system's overall financial profile. Adjusted for operating lease expense, MADS coverage is diluted to 2.3x.

Wellmont's fiscal 2013 budgeted operating income is $15 million, resulting in an operating margin of about 1.9%, a level comparable to fiscal 2011 results, but below fiscal 2012. Wellmont expects to grow its operating margin over time, once the full Epic clinical information system has been implemented in 2014/2015.

Balance sheet

Wellmont's balance sheet remains acceptable, in our view, and although management plans to issue $55 million of new debt in fiscal 2013, we believe that the system has some flexibility to issue additional debt at the existing rating level given its solid operating performance and improved capitalization during the past three years.

Unrestricted cash and investments totaled $380 million at year end, equal to 192 days' cash on hand and 83% of long-term debt. As part of its methodology Wellmont excludes the less liquid investments from the days' cash calculation. By making that adjustment, days' cash declines to about 173 days at fiscal year end, which remains solid and in compliance with Wellmont's minimum covenant level of 100 days. Robust cash flow and minimal capital spending needs allowed cash to grow by more than $32 million relative to last year.

Wellmont's systemwide combined routine and strategic capital budget is $40 million for fiscal 2013, not including the system's budget for converting to a new Epic IT Platform, which will represent a $100 million capital spend during the next five years (plus $84 million of operating costs). Wellmont is budgeting for about $45 million of meaningful use stimulus money, which will help to offset the cost of its Epic conversion. Other than modest strategic and equipment-related capital spending and the planned spending for its Epic IT Platform conversion, Wellmont has limited other capital spending plans. As a result, we anticipate that the system's liquidity will continue to grow.

Wellmont Health System

		Fiscal Year Ended June 30,		
	Fiscal Year Ended June 30, 2012 (Unaudited)	**2011**	**2010**	**2009**
Financial performance				
Net patient revenue ($000s)	741,822	767,450	692,920	699,303
Total operating revenue ($000s)	789,726	797,249	724,392	737,073

Wellmont Health System (cont.)				
Total operating expenses ($000s)	769,074	781,322	701,580	730,567
Operating income ($000s)	20,652	15,927	22,812	6,506
Operating margin (%)	2.62	2.00	3.15	0.88
Net nonoperating income ($000s)	17,360	9,908	(1,967)	(359)
Excess income ($000s)	38,012	25,835	20,845	6,147
Excess margin (%)	4.71	3.20	2.89	0.83
Operating EBIDA margin (%)	11.24	10.38	11.96	8.89
EBIDA margin (%)	13.15	11.48	11.72	8.84
Net available for debt service ($000s)	106,092	92,644	84,666	65,148
Maximum annual debt service ($000s)	35,157	35,157	35,157	35,157
Maximum annual debt service coverage (x)	3.02	2.64	2.41	1.85
Operating lease-adjusted coverage (x)	2.30	2.28	2.14	1.73
Liquidity and financial flexibility				
Unrestricted cash and investments ($000s)	379,544	346,881	315,776	250,331
Unrestricted days' cash on hand	191.7	172.2	175.2	132.9
Unrestricted cash/total long-term debt (%)	82.6	75.5	67.5	52.7
Average age of plant (years)	11.4	10.5	10.5	9.7
Capital expenditures/depreciation and amortization (%)	103.6	92.0	127.4	201.5
Debt and liabilities				
Total long-term debt ($000s)	459,654	459,260	467,833	474,608
Long-term debt/capitalization (%)	49.6	51.2	56.6	59.7
Debt burden (%)	4.36	4.35	4.85	4.74
Defined benefit plan funded status (%)	N.A.	85.61	77.52	83.24
Pro forma ratios				
Unrestricted days' cash on hand	191.70			
Unrestricted cash/total long-term debt (%)	73.75			
Long-term debt/capitalization (%)	52.44			

N.A.: Not available.

Related Criteria And Research

- USPF Criteria: Assessing Construction Risk, June 22, 2007
- Criteria: Methodology And Assumptions: Approach To Evaluating Letter Of Credit-Supported Debt, July 6, 2009
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012

Ratings Detail (As Of September 25, 2012)

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Ser 2003

Unenhanced Rating	BBB+(SPUR)/Stable	Affirmed

Ser 2011

Ratings Detail (As Of September 25, 2012) (cont.)		
Long Term Rating	BBB+/Stable	Affirmed
Virginia Small Business Fin Auth, Virginia		
Wellmont Hlth Sys, Tennessee		
Ser 2007A		
Long Term Rating	BBB+/Stable	Affirmed

Many issues are enhanced by bond insurance.

FITCH AFFIRMS WELLMONT HEALTH SYSTEM, TN'S REVS AT 'BBB+'; OUTLOOK STABLE

Fitch Ratings-New York-22 April 2013: Fitch Ratings affirms the 'BBB+' rating on the following bonds issued on behalf of Wellmont Health System (Wellmont):

--$76,165,000 The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee hospital revenue refunding bonds (Wellmont Health System Project), series 2011;
--$55,000,000 Virginia Small Business Financing Authority hospital revenue bonds, series 2007A (Wellmont Health System Project);
--$200,000,000 The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee hospital revenue bonds, series 2006C (Wellmont Health System Project);
--$59,580,000 The Health, Educational and Housing Facilities Board of the County of Sullivan, TN hospital revenue refunding bonds, series 2005 (Wellmont Health System Project);
--$33,035,000 The Health, Educational and Housing Facilities Board of the County of Sullivan, TN hospital revenue refunding bonds, series 2003 (Wellmont Health System Project).

The Rating Outlook is Stable.

SECURITY

The bonds are secured by gross receipts and mortgage pledge of the obligated group (OG). A fully funded debt service fund provides additional security. In addition, there is a liquidity covenant.

KEY RATING DRIVERS:

STRONG OPERATING EBITDA: Wellmont's operating EBITDA is consistently above Fitch's 'BBB' category medians, averaging 11.2% over the past four audited years and at 10.2% in the six month fiscal 2013 (June 30 year end) interim period.

CATEGORY CONSISTENT METRICS: Most of Wellmont's financial and capital metrics are consistent with the rating category, with liquidity strengthening over the last four audited years to above category medians.

LEADING MARKET SHARE: Wellmont maintains leading 55% inpatient market share in its defined primary service area. Although its market share has declined slightly in the past few years, it is not a credit concern.

ELEVATED DEBT BURDEN: Maximum annual debt service (MADS) as a percentage of revenue is high at 5.3% in the six month interim period relative to a Fitch's 'BBB' median of 3.3%. Wellmont is drawing down a $42.5 million loan ($3.1 million has been drawn to date) as part of its EPIC implementation (a separate $12.5 million was closed and drawn upon last year for a total of $55 million in additional debt for EPIC), all of which is factored into the MADS figure. With no other additional debt anticipated, Fitch expects Wellmont's debt burden to moderate over next few years.

RATING SENSITIVITIES:

OPERATING PRESSURE: Like many hospitals, Wellmont has seen inpatient volumes decline as services have shifted to an outpatient setting, with Wellmont's operating performance slightly weaker in the six month interim due, in part, to the reduction in inpatient services. Wellmont's ability to adjust to this volume shift and maintain its operating performance is key to the current rating. A weakening of its operating EBITDA would be a credit concern, given Wellmont's elevated debt burden.

CREDIT PROFILE:

The 'BBB+' rating is supported by an overall financial profile consistent with Fitch's 'BBB' rating category medians and Wellmont's leading inpatient market share in its primary service area (PSA). Wellmont finished fiscal 2013 with a 2.8% operating margin and MADS coverage of 2.6x, both solid for the 'BBB' category.

Six month fiscal 2012 interim figures show the operating margin sliding to 1.1%, which is off Wellmont's budget. Wellmont is adjusting its budget and expects to improve operations over the second half of the year, helped by an additional $6.5 million in meaningful use funds.

Liquidity has strengthened materially over the last four years, with unrestricted cash and investments growing by approximately 45% over that time, and Wellmont's key liquidity ratios now exceeding Fitch's 'BBB' medians. At Dec. 31, 2012, Wellmont had cash and unrestricted investments of $395.6 million (excluding $38.4 million in illiquid investments), which equated to days cash on hand of 197.1, a pro forma cushion ratio of 9.5x, and pro forma cash to debt (assuming full draw down on $45 million loan - only $3.2 million has been drawn to date) of 76.1%.

Wellmont's debt burden remains elevated for the rating level, as represented by MADS as a percentage of revenue of 5.3% and debt-to-EBITDA of 4.6x, and debt to capitalization of 51.8% as of Dec. 31, 2012, all of which compare unfavorably to 'BBB' category medians. An additional credit concern is competitive service area with Mountain States Health Alliance (general revenue bonds rated 'BBB+'/Outlook Stable by Fitch) a formidable competitor.

The Stable Outlook reflects Fitch's belief that Wellmont will maintain a level of operating performance to support consistent debt service coverage. Capital expenditures over the next two to three years are expected to be reasonable at approximately $40 million to $50 million per year, excluding $100 million EPIC implementation.

Wellmont's debt portfolio is relatively conservative with approximately 12% of its $481 million of long-term debt in variable rate mode. However, Wellmont does have four swaps. Lehman is the counterparty for three of the swaps. There are no collateral posting requirements at the current rating level. The aggregate mark to market as of Dec. 31, 2012 was a negative $8.5 million.

Wellmont Health System (WHS) is a large regional health care system with seven acute hospitals (816 staffed beds) and other related entities located in northeastern TN and southwestern VA. Wellmont had approximately $790 million in total revenue in fiscal 2012. WHS covenants to provide audited financial statements to the Municipal Securities Rulemaking Board's Electronic Municipal Market Access system (EMMA), as well as quarterly unaudited statements.

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Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria', June 12, 2012;
--'Nonprofit Hospitals and Health Systems Rating Criteria', July 23, 2012.

For information on Build America Bonds, visit 'www.fitchratings.com/BABs'.

Applicable Criteria and Related Research
Revenue-Supported Rating Criteria
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=681015
Nonprofit Hospitals and Health Systems Rating Criteria
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=683418

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Research

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Sullivan County Health Educational & Housing Facilities Board, Tennessee
Wellmont Health System; System

Credit Profile		
Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Ser 2006C		
Long Term Rating	BBB+/Negative	Outlook Revised

Rationale

Standard & Poor's Ratings Services revised its outlook to negative from stable and affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on $356.4 million in bonds, including series 2003, 2006C, 2007A, and 2011, issued for Wellmont Health System, Tenn. by various issuing authorities.

The long-term and short-term ratings on Wellmont's $54.8 million series 2005 variable-rate demand obligations are 'A+/A-1' and are based solely on the support of JP Morgan Chase Bank N.A. (A+/A-1), the letter of credit provider.

The 'BBB+' rating is based on our view of Wellmont Health System's group credit profile and core status as the obligated group that includes Wellmont Health System (as parent); Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary; and the system's fundraising arm. Accordingly, the bonds are rated at the same level as the group credit profile. The negative outlook and affirmed 'BBB+' ratings reflect our view of Wellmont's operating and financial metrics, which while still adequate for the rating level have trended lower and are expected to weaken during fiscal 2014. The rating is supported by the system's stable enterprise profile. In addition, we believe that Wellmont is well positioned for operational success with respect to its markets, its competition, and the changing reimbursement environment.

More specifically, the ratings reflect our opinion of Wellmont's:

- Solid financial metrics, including positive fiscal 2013 operating income of $11.7 million (a 1.5% margin), as per Standard & Poor's calculations;
- Acceptable 2.5x fiscal year-end maximum annual debt service (MADS) coverage;
- Improved balance sheet, highlighted by the system's 218 days' cash on hand, moderately elevated 48% long-term debt to total capitalization, and unrestricted cash to long-term debt of 90% as of Sept. 30, 2013, and as per Standard & Poor's calculations; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings is our view of revenue cycle, staffing, expense, and other operating improvements that have helped Wellmont generate favorable operating results during the past four years. In addition, we expect

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Wellmont's balance sheet will remain robust, since it has limited capital spending needs for the foreseeable future.

Partially offsetting the above-noted strengths, in our opinion, is Wellmont's plan to issue roughly $13.5 million of new debt in fiscal 2014, as well as management's ongoing Epic IT Platform implementation, which over last year and during the next four years will involve a total of about $95 million to $100 million of capital spending. While the transition to Epic could still potentially involve some disruption to Wellmont's operations, management believes that it is very well prepared to undertake the implementation and successfully implemented its electronic health record during the previous two years.

In addition, while we believe that major facilities acquisitions are done now that most of the desirable candidates in the markets served by Wellmont and its major competitor have been acquired, we continue to believe that competition for patient volumes between these two sizable systems remains intense.

As of June 30, 2013, Wellmont had $476 million of bonded debt and capital leases. About $78 million of Wellmont's outstanding debt is variable-rate obligations, including $23 million in bank qualified directly placed index floating-rate bonds (not rated). The variable-rate obligations have tender provisions that may allow the bonds to be redeemed before maturity. In our opinion, the amount of puttable debt relative to unrestricted cash as of June 30, 2013, is negligible, at less than 10%. We understand that Wellmont may issue approximately $13.5 million of incremental debt in fiscal 2014, and, in our opinion, the system has capacity to issue this level of additional debt without negatively affecting the ratings.

Wellmont uses interest rate swaps to partially hedge its interest rate risk. Wellmont has four swaps totaling $220 million notional principal; Lehman Brothers Special Financing is the counterparty for three of the swaps, and Bank of America Merrill Lynch is the counterparty for a $76.1 million total return swap entered into in 2011. In our opinion, the risks associated with Wellmont's derivatives portfolio are moderate at this time. Wellmont's swap liability was $7.4 million at June 30, 2013, and there is no required collateral posting. The estate of Lehman Brothers recently filed suit seeking $21 million of damages from Wellmont in disputed claims related to Wellmont's termination of a total return swap on its series 2006A bonds. Management believes that the suit is without merit and plans to vigorously defend itself.

The system remains in compliance with all bank and bond covenants. Gross revenues of the obligated group and a mortgage on Wellmont's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, as well as a mortgage on Mountain View Regional Medical Center, a community hospital, secure the bonds. Gross revenues from Lee Regional Medical Center also formerly secured the bonds; however, the facility was recently closed. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. Six of the system's hospitals are included by virtue of operating as unincorporated divisions of the parent: Holston Valley Medical Center, Bristol Regional Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Lee Regional Medical Center, and Mountain View Regional Medical Center. All of the system's entities are included for the purpose of our calculations in this report.

Outlook

The negative outlook reflects our view of Wellmont's weaker fiscal 2013 and year-to-date operating performance reflecting a decline in patient volumes, higher drug costs, and the step down in meaningful use funds (as expected) leading to more modest coverage at MADS. Management is also expecting a further downturn in operating income for fiscal 2014. While we believe that Wellmont's balance sheet remains robust enough to support current rating, we believe that operating results are likely to be challenged during the two-year outlook period by the changes being brought about by health reform, potentially leading to weaker balance sheet metrics and substandard coverage for the rating level. Should Wellmont's coverage at MADS fall to and be sustained below 2.0x or if unrestricted liquidity falls to fewer than 150 days or 70% of long-term debt, then a downgrade would become more likely. We do not expect to raise the ratings during the outlook period.

While most of Wellmont's major bricks-and-mortar capital spending initiatives have been completed, the system continues to incur capital spending for its Epic IT Platform. We are also aware that Wellmont plans to incur about $13.5 million of new debt in fiscal 2014, and while the details are uncertain at this time, we believe that the system maintains adequate capacity to support this level of incremental debt at the existing rating level.

Enterprise Profile

Wellmont is a seven-hospital system headquartered in Kingsport, Tenn., and is composed of 781 staffed beds including managed (not owned acute), psych, rehab, and skilled nursing facility) inpatient beds. The system's facilities are located in Tennessee and Virginia. Acute discharges totaled 37,798 in fiscal 2013, down 5.8% from fiscal 2012 (which was down 4.6% from fiscal 2011). Total bedded volumes, including observations, declined to 51,539 from 53,790, or by 4.2%, compared with the previous fiscal year. The system's outpatient registrations continue to grow, and totaled 210,044 in fiscal 2013, up from 209,024 in fiscal 2012. Combined surgery volumes were essentially flat while emergency department volumes were lower (by 6.7%), reflecting the presence of three urgent-care centers that are treating patients in a lower-cost setting.

Management remains focused on the system's ambulatory strategy, which has included the creation of a strategic infrastructure around oncology and cardiology centers of excellence. Pulmonology is also a service line that management considers a strategic focus. Although in the past several years Wellmont had focused on the acquisition of hospitals and facilities, both in Tennessee and in Virginia, facilities acquisition activity is completed and there are very few desirable remaining acquisition candidates in the system's service area that are not already affiliated with Wellmont or its major competitor.

Management's current strategy is to maintain or develop outposts to draw patients from a larger geographic area without having to have a hospital located in those areas and to focus on its strategy regarding the continuum of care including the recently announced acquisition of Wexford House, a post-acute care facility. In addition, management plans to capitalize on its strengths in core service lines supported by its new dyad leadership model, which appears to be creating favorable results through improved patient satisfaction scores.

To address the decline in patient volumes and the resultant effect on operations, Wellmont has eliminated the duplicative administrative overhead at each hospital and consolidated most administrative functions to the system level. In addition, the system has closed inpatient units to improve occupancy and efficiency, established 24/7 case management coverage in its emergency departments, and opened dedicated observation units to better match the cost of care to revenues.

Management

We believe that Wellmont is led by a capable leadership team headed by Denny DeNarvaez, CEO, who joined Wellmont in 2010 following her service to St. John's Mercy Healthcare as CEO. In August 2012 Wellmont named Alice Pope CFO. Ms. Pope previously served as SVP finance managed care and revenue cycle for the system, and has served in various roles with the organization during the past 12 years.

Financial Profile

In accordance with the publication of our article, "New Bad Debt Accounting Rules Will Alter Some U.S. Not-for-Profit Health Care Ratios But Won't Affect Ratings," on Jan.

19, 2012, we have reflected Wellmont's 2012 and 2013 audited results and the year to date interims with the adoption of Financial Accounting Standards Board statement 954 in 2012, but not for prior periods. The new accounting treatment means that Wellmont's fiscal 2012 and subsequent financial statistics are not directly comparable to the results for 2011 and prior years, nor are they directly comparable to the 2011 median ratios. For an explanation of how each financial measure is affected by the change in accounting for bad debt, including the direction and size of the change, please see the above-mentioned article.

For the fiscal year ended June 30, 2013, Wellmont generated operating income of $11.7 million (a 1.5% margin) on $798 million of total net revenues. Results compared with $20.7 million (a 2.6% margin) on $789.7 million of total net revenues for fiscal 2012. The decline in operating results in fiscal 2013 and for the year to date ended Sept. 30, which saw net operating income of $580,000 (a 0.3% margin), reflects weaker volumes, the more challenging reimbursement environment, and Wellmont's cost structure, which was too high given the declining revenues. Management is addressing its costs through reduced staffing and the efficiency initiatives noted earlier, including the opening of a dedicated observation units and the elimination of administrative overhead at individual system hospitals.

For the fiscal year, Wellmont's excess revenues, as per Standard & Poor's calculations, were $29 million (or a 3.6% margin), which included $19.4 million of realized investment income and gains. Wellmont also had a $2.1 million loss from discontinued operations.

Cash flow remains acceptable, in our view, as evidenced by a 12.5% EBIDA margin, generating just under 2.5x coverage of Wellmont's $41.3 million MADS. Operating leases have historically been relatively modest in amount; however, with the monetization of Wellmont's medical office buildings, operating leases have become more material to the system's overall financial profile. Adjusted for operating lease expense, MADS coverage is diluted to 2.0x.

Wellmont's fiscal 2014 budgeted operating income is $3.9 million inclusive of almost $9 million of meaningful use

stimulus funds, resulting in an operating margin of about 0.5%. According to management, however, recent reimbursement changes related to CMS's two-midnight rule could have a $3 million to $4 million negative impact on Wellmont's reimbursement, which was not known at the time the budget was prepared. In our view, operating performance is becoming more constrained and could be a key issue leading to a lower credit rating in the future.

Balance sheet

Wellmont's balance sheet remains acceptable, in our view, and although management plans to issue $13.5 million of new debt in fiscal 2014, we believe that the system has some flexibility to issue additional debt at the existing rating level given its improved capitalization during the past four years.

Unrestricted cash and investments totaled $434 million at Sept. 30, equal to 218 days' cash on hand and 90% of long-term debt, which we view as solid for the rating level. As part of its methodology Wellmont excludes the less liquid investments from the days' cash calculation. By making that adjustment, days' cash declines to about 202 days at Sept. 30, which remains solid and in compliance with Wellmont's minimum covenant level of 100 days. Robust cash flow and minimal capital spending needs allowed cash to grow by more than $54 million relative to fiscal year-end 2012.

Wellmont's systemwide combined routine and strategic capital budget is $41.5 million for fiscal 2014 inclusive of approximately $6 million of funds not yet allocated. The spending budget does not include the remaining spending under the system's budget for converting to a new Epic IT Platform, which is expected to come in below the original $100 million five-year budget. Wellmont is budgeting for about $45 million of meaningful use stimulus money, which will help to offset the cost of its Epic conversion. Other than modest strategic and equipment-related capital spending and the planned spending for its Epic IT Platform conversion, Wellmont has limited other capital spending plans. As a result, we anticipate that the system's liquidity will continue to grow.

Wellmont Health System

		Fiscal Year Ended June 30,		
	Three-Month Interim Ended Sept. 30, 2013	2013	2012	2011
Financial performance				
Net patient revenue ($000s)	185,220	754,488	741,822	767,450
Total operating revenue ($000s)	194,051	798,223	789,726	797,249
Total operating expenses ($000s)	193,471	786,507	769,073	781,322
Operating income ($000s)	580	11,716	20,653	15,927
Operating margin (%)	0.30	1.47	2.62	2.00
Net nonoperating income ($000s)	1,807	17,300	17,360	9,908
Excess income ($000s)	2,387	29,016	38,013	25,835
Excess margin (%)	1.22	3.56	4.71	3.20
Operating EBIDA margin (%)	9.40	10.63	11.24	10.38
EBIDA margin (%)	10.24	12.53	13.15	11.48
Net available for debt service ($000s)	20,052	102,241	106,093	92,644
Maximum annual debt service ($000s)	41,310	41,310	41,310	41,310
Maximum annual debt service coverage (x)	1.94	2.47	2.57	2.24
Operating lease-adjusted coverage (x)	N.A.	2.02	2.07	1.86

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Wellmont Health System (cont.)

Liquidity and financial flexibility				
Unrestricted cash and investments ($000s)	433,634	426,182	379,544	346,881
Unrestricted days' cash on hand	218.5	211.6	191.7	172.2
Unrestricted cash/total long-term debt (%)	90.0	89.5	82.6	75.5
Capital expenditures/depreciation and amortization (%)	84.6	112.4	99.2	92.0
Debt and liabilities				
Total long-term debt ($000s)	481,710	475,946	459,654	459,260
Long-term debt/capitalization (%)	48.1	48.4	49.9	51.2
Debt burden (%)	5.27	5.05	5.12	5.11

N.A.: Not available.

Related Criteria And Research

Related Criteria

- USPF Criteria: Municipal Swaps, June 27, 2007
- USPF Criteria: Not-For-Profit Health Care, June 14, 2007

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Sector Outlook: Providers Prove Adaptable But Face A Test In 2013 As Reform Looms, Jan. 4, 2013
- U.S. Not-For-Profit Health Care System Ratios: Metrics Remain Steady As Providers Navigate An Evolving Environment, Aug. 8, 2013
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- U.S. Not-For-Profit Health Care Providers Hone Their Strategies For Reform, May 16, 2011

Ratings Detail (As Of December 18, 2013)

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Ser 2003		
Unenhanced Rating	BBB+(SPUR)/Negative	Outlook Revised
Ser 2011		
Long Term Rating	BBB+/Negative	Outlook Revised
Virginia Small Business Fin Auth, Virginia		
Wellmont Hlth Sys, Tennessee		
Ser 2007A		
Long Term Rating	BBB+/Negative	Outlook Revised

Many issues are enhanced by bond insurance.

FitchRatings

FITCH AFFIRMS WELLMONT HEALTH SYSTEM, TN REVS AT 'BBB+'; OUTLOOK STABLE

Fitch Ratings-New York-10 April 2014: Fitch Ratings affirms the 'BBB+' rating on the following Health, Education and Housing Facilities Board of the County of Sullivan, Tennessee bonds issued on behalf of Wellmont Health System (Wellmont):

--$76,165,000, hospital revenue refunding bonds (Wellmont Health System Project), series 2011;
--$200,000,000 hospital revenue bonds, series 2006C (Wellmont Health System Project);
--$54,820,000 hospital revenue refunding bonds, series 2005 (Wellmont Health System Project);
--$25,225,000 hospital revenue refunding bonds, series 2003 (Wellmont Health System Project).

In addition, Fitch affirms at 'BBB+' the following parity debt also issued on behalf of Wellmont:

--$55,000,000 Virginia Small Business Financing Authority hospital revenue bonds, series 2007A (Wellmont Health System Project).

The Rating Outlook is Stable.

KEY RATING DRIVERS:

STRONG OPERATING EBITDA: Wellmont's operating EBITDA is consistently above Fitch's 'BBB' category median, averaging 11.5% over the past four audited years and at 9.9% in the six-month fiscal 2014 (June 30 year-end) interim period.

LIQUIDITY A CREDIT STRENGTH: Wellmont has $419.6 million in unrestricted cash and investments (not including $27 million in illiquid funds) at Dec. 31, 2013, a 6% year-over-year increase. Wellmont's key liquidity figures compare favorably to Fitch's 'BBB' medians.

ADEQUATE DEBT SERVICE: Most of Wellmont's financial and capital metrics are consistent with the rating category.

LEADING MARKET SHARE: Wellmont maintains a leading 56% inpatient market share in its defined primary service area (PSA). Although market share has declined slightly in the past few years, Fitch is not concerned, as Wellmont remains competitive in key strategic service lines.

ELEVATED DEBT BURDEN: Maximum annual debt service (MADS) as a percentage of revenue was high at 5.4% in the six-month interim period relative to a Fitch's 'BBB' median of 3.5%. However, after completing a large EPIC implementation at a cost of approximately $100 million, for which it assumed additional debt, Wellmont's capital spending should slow, which should allow it to moderate its debt burden.

RATING SENSITIVITIES

SEEKING STRATEGIC PARTNER: Wellmont is in the process of evaluating potential strategic partnerships. The process of evaluating and choosing a potential partner is expected to be completed in the next 12 months. The effect of a strategic partnership on Wellmont is not factored into the rating. Fitch will continue to monitor the process and will evaluate a partnership once the process is completed. For the remaining fiscal year, Fitch expects Wellmont's performance to improve slightly as the expenses related to EPIC implementation have been fully absorbed.

Credit Profile

Wellmont Health System (WHS) is a large regional health care system with seven acute hospitals (816 staffed beds) and other related entities located in northeastern TN and southwestern VA. Wellmont had approximately $798.2 million in total revenue in fiscal 2013.

Financial Summary

The 'BBB+' rating is supported by an overall financial profile consistent with Fitch's 'BBB' rating category medians and Wellmont's leading inpatient market share in its defined PSA. Wellmont finished fiscal 2013 with a 1.6% operating margin and MADS coverage of 2.6x, both adequate for the 'BBB' category, but below category medians. Wellmont's operating EBITDA was stronger at 10.8%, above the category median of 9%.

Operations were lower in the first six months of fiscal 2014 due largely to EPIC implementation costs, as Wellmont went live with its physicians in December 2013 and live in its hospitals in late March 2014. For fiscal 2014, Wellmont budgeted for $13.5 million of implementation expenses that cannot be capitalized, with a portion of those expenses coming in the first half of the fiscal year. However, Wellmont did anticipate these expenses and is tracking ahead of budget for the first six months. In the first six months of fiscal 2014, Wellmont posted a 1.2% operating margin and 2.2x debt service coverage, compared to a 1.6% operating margin and 2.5x debt service coverage for the first six months of fiscal 2013. Wellmont's management reports that performance continues to be ahead of budget through February 2014, and Fitch expects Wellmont's operating performance to continue to improve through the end of the fiscal year.

Liquidity has continued to strengthen with unrestricted cash growing 6% in the year-over-year interim period and 49% from fiscal year-end 2010. At Dec. 31, 2013, Wellmont had cash and unrestricted investments of $419.6 million (excluding $27 million in illiquid investments), which equated to days cash on hand of 213.3, a cushion ratio of 10x, and cash-to-debt of 82.6%, which compare well to 'BBB' category medians of 144.7, 10.2, and 91.7, respectively.

Wellmont's debt burden remains elevated for the rating level, as represented by MADS as a percentage of revenue of 5.4% and debt-to-EBITDA of 5.5x. as of Dec. 31, 2013, both of which compare unfavorably to 'BBB' category medians. However, Fitch expects debt to moderate with the EPIC implementation completed. Wellmont is issuing bank debt to acquire a skilled nursing facility, Wexford House, but the facility is producing enough cash flow to cover the additional debt.

Fitch views the acquisition as credit neutral. The skilled nursing facility will build on Wellmont's efforts to prepare for population health management and other aspects of health care reform. Other initiatives in this effort include participating in an Accountable Care Organization, structuring shared savings contracts with select payors, and continuing to position the organization as the low-cost, high-quality provider for the region.

Potential Strategic Partnerships

Wellmont is actively exploring a strategic partnership through a formal RFP process.

Wellmont plans to evaluate the RFP responses, and Fitch expects a decision to be made within the next rating cycle. The financial arrangement of a potential partnership is not clear and could range from a loose affiliation to a full asset merger. Fitch views the potential partnership as credit neutral as much will depend on the outcome of the process and the final partner. However, Fitch notes positively that Wellmont is entering the process from a position of credit strength with a strong balance sheet, good market position, and consistent levels of operations and debt service coverage.

Debt Profile

Wellmont's debt portfolio is relatively conservative with approximately 15% of its $508 million of long-term debt in variable-rate mode. However, Wellmont does have four swaps. Two are fixed payor swaps, one is a basis swap, and one is a total return swap.

There are no collateral posting requirements at the current rating level. The aggregate mark to market as of Dec. 31, 2013 was a negative $7.2 million.

In addition, Wellmont is planning to restructure some of its debt in the next three months. Fitch expects that the covenants for that debt will remain consistent with the current covenants.

Disclosure
WHS covenants to provide audited financial statements to the Municipal Securities Rulemaking Board's Electronic Municipal Market Access system (EMMA), as well as quarterly unaudited statements.

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Additional information is available at 'www.fitchratings.com'.

Applicable Criteria and Related Research:

--Rating Guidelines for Nonprofit Hospitals and Health Systems, May 20, 2013

For information on Build America Bonds, visit 'www.fitchratings.com/BABs'.

Applicable Criteria and Related Research:
Rating Guidelines for Nonprofit Continuing Care Retirement Communities
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=40171

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Wellmont Health System, Tennessee; System

Credit Profile		
Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee		
Wellmont Hlth Sys, Tennessee		
Ser 2006C		
Long Term Rating	BBB+/Stable	Outlook Revised

Rationale

Standard & Poor's Ratings Services revised its outlook to stable from negative and affirmed its 'BBB+' long-term rating and underlying rating (SPUR) on $135 million in bonds, including series 2006C, 2007A, and 2011, issued for Wellmont Health System, Tenn. by various issuing authorities.

The 'BBB+' rating is based on our view of Wellmont Health System's group credit profile and core status as the obligated group, which includes Wellmont Health System (as parent); Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary; and the system's fundraising arm. Accordingly, the bonds are rated at the same level as the group credit profile. The stable outlook and affirmed 'BBB+' ratings reflect our view of Wellmont's operating and financial metrics, which were adequate for the rating level in fiscal 2014 and showed improvement during the first fiscal quarter of 2015. The rating is supported by the system's stable enterprise profile. While we understand that management is considering strategic options to strengthen the system's operational viability under health reform, we still believe that Wellmont is adequately positioned for operational success with respect to its markets, its competition, and the changing reimbursement environment.

More specifically, the ratings reflect our opinion of Wellmont's:

- Light but adequate financial metrics, including positive fiscal 2014 operating income of $3.3 million (a 0.43% margin), as per Standard & Poor's calculations;
- Acceptable 2.0x fiscal year-end maximum annual debt service (MADS) coverage;
- Acceptable balance sheet, highlighted by the system's 212 days' cash on hand, moderately elevated 47% long-term debt to total capitalization, and unrestricted cash to long-term debt of 89% as of Sept. 30, 2014, and as per Standard & Poor's calculations; and
- Solid business position characterized by good market share in a demographically favorable region that is largely dominated by two health care systems.

Further supporting the ratings is our view of revenue cycle, staffing, expense, and other operating initiatives that will likely help Wellmont generate better operating results over time. In addition, we expect Wellmont's balance sheet will remain robust since Wellmont has limited capital spending needs for the foreseeable future.

Partly offsetting rating factors include Wellmont's reliance on supplemental reimbursement and meaningful-use stimulus funds to generate the system-s positive net from operations during the past two to three years. In addition, we believe that competition for patient volumes between Wellmont and its main competitors remains intense.

As of Sept. 30, 2014, Wellmont had $484 million of bonded debt and capital leases. About $123 million of Wellmont's outstanding debt is variable-rate bank direct purchase obligations. The variable-rate obligations have tender provisions that may allow the bonds to be redeemed before maturity. In our opinion, unrestricted cash to puttable debt as of Sept. 30, 2014, was robust, at about 3.5x.

Wellmont uses interest rate swaps to partly hedge its interest rate risk. Wellmont has four swaps totaling $260 million notional principal; Lehman Brothers Special Financing is the counterparty for three of the swaps, and Bank of America Merrill Lynch is the counterparty for a $74.4 million total return swap entered into in 2011. In our opinion, the risks associated with Wellmont's derivatives portfolio are moderate at this time. Wellmont's swap liability was $5.7 million at Dec. 31, 2014, and there is no required collateral posting.

The system remains in compliance with all bank and bond covenants. Gross revenues of the obligated group and a mortgage on Wellmont's two largest hospitals, Bristol Regional Medical Center and Holston Valley Medical Center, secure the bonds. The obligated group includes the parent, Hawkins County Memorial Hospital (a leased facility), a for-profit subsidiary, and the system's fundraising arm. All of the system's entities are included for the purpose of our calculations in this report.

Outlook

The stable outlook reflects our view of Wellmont's weak fiscal 2014, but improved fiscal 2015 year-to-date, results, supported by the service line expansions, the completion of Wellmont's Epic installation last year, and operational improvement initiatives. While we believe that Wellmont's balance sheet remains robust enough to support the current rating, we believe that operating results may continue to be challenged during the two-year outlook period by the changes being brought about by health reform, potentially leading to weaker balance sheet metrics and lower-than-desirable coverage relative to the rating level.

Downside scenario

Should Wellmont's fiscal 2015 results fall short of budgeted expectations, MADS coverage fall to and be sustained at below 2.0x, or unrestricted liquidity fall to fewer than 150 days or 70% of long-term debt, then a downgrade would become more likely.

Upside scenario

While we do not expect to raise the ratings during the outlook period, we could do so over time in response to, at a minimum, sustained improved operating performance, a moderation in Wellmont's leverage, and no material decline in the system's enterprise profile, which includes market share.

Enterprise Profile

Following the closure of Lee Regional in October 2013, Wellmont is a six-hospital system headquartered in Kingsport, Tenn., and is composed of 711 staffed beds, including acute, psych, rehab, and skilled nursing facility inpatient beds. The system's facilities are located in Tennessee and Virginia. Acute discharges totaled 34,917 in fiscal 2014, down 7.6% from fiscal 2013 (which was down 5.8% from fiscal 2012), although we note that patient volume declines have

not been adjusted for the closure of Lee Regional in October 2013. Inclusive of the same-store adjustment, inpatient volumes declined about 5.7%. Likewise, but also not adjusted on a same-store basis, equivalent inpatient admissions declined to 85,112 from 87,434, or by 2.7%. Combined surgery volumes were essentially flat while emergency department volumes were lower (by 7.1%), reflecting the presence of five urgent-care centers that are treating patients in a lower-cost setting.

Management remains focused on the system's ambulatory strategy, which has included the creation of a strategic infrastructure around oncology and cardiology centers of excellence. Orthopedics, neurology, and pulmonology are also service lines that management considers a strategic focus, along with post-acute and long-term care. Management plans to capitalize on its strengths in core service lines, supported by its dyad leadership model.

Also, in recognition of the challenging operating environment, Wellmont is exploring its strategic options around alignment with another health system. We understand that the system's board will likely reach a decision in early 2015. In our view, alignment with another strong provider will be a credit positive for the system.

Management

We believe that Wellmont is led by a capable leadership team headed by Bart Hove, CEO, who formerly served as the president of Wellmont's Bristol Regional Hospital and took over the system's CEO responsibilities in September 2014, following the departure of Denny DeNarvaez. Wellmont's CFO is Alice Pope, who has served in her current role since 2012 and has been with Wellmont for 15 years. Wellmont's COO is Eric Deaton, who recently rejoined the system after previously having worked for Wellmont for four years.

Financial Profile

For the fiscal year ended June 30, 2014, Wellmont generated operating income of $3.3 million (a 0.4% margin), under Standard & Poor's methodology, on $773 million of total net revenues. Results were down from $11.7 million (a 1.5% margin) on $798 million of total net revenues for fiscal 2013. The decline in operating results in fiscal 2014 reflects continued weaker volumes; the challenging reimbursement environment, including the effects of Medicare's two-midnight rule for observation patients; and operational inefficiencies. Management is addressing operational inefficiencies through supply chain, labor, and service line initiatives with a goal of reducing expenses by about $25 million per year. Wellmont's excess revenues, as per Standard & Poor's calculations, were $33 million (or a 4.1% margin), which included $15 million of realized investment income and gains.

Cash flow remains acceptable, in our view, as evidenced by an 11% EBIDA margin, generating 2.0x coverage of Wellmont's $42.8 million MADS. Operating leases have historically been relatively modest in amount; however, with the monetization of Wellmont's medical office buildings, operating leases have become more material to the system's overall financial profile. Adjusted for operating lease expense, MADS coverage is diluted to 1.8x.

Year-to-date results through September 2014 reflected an improvement in operating income of $4.5 million (or a 2.2% margin) on $205 million of operating revenues, producing 2.6x MADS coverage on an annualized basis. We understand that through six months Wellmont's consolidated results exceed budget and results for the same period last year.

Wellmont's fiscal 2015 budgeted operating income is just over break even, inclusive of $4 million of meaningful-use stimulus funds, although results year to date point to a stronger-than-budgeted fiscal 2015. While the operating environment remains challenging, we believe that the Wellmont board's decision to consider an alignment with another system is positive strategic step to help Wellmont remain a healthy system over the long term.

Balance sheet

Wellmont's balance sheet remains acceptable, in our view. Unrestricted cash and investments totaled $431 million at Sept. 30, equal to 212 days' cash on hand and 89% of long-term debt, which we view as solid for the rating level and in compliance with Wellmont's minimum covenant level of 100 days. We view the system's 47% leverage to be manageable and in line with the median for the rating level. We understand that management has no current plans to issue additional debt.

Wellmont's systemwide combined routine and strategic capital budget is $35 million for fiscal 2015, inclusive of approximately $3 million of funds not yet allocated. With the completion of the system's Epic implementation last year, capital spending needs are more limited and approximate about 70% of depreciation. As a result, we anticipate that the system's liquidity will continue to grow.

Wellmont Health System

		Fiscal year ended June 30,			Medians	
	Three-month interim ended Sept. 30, 2014	2014	2013	2012	Health care system BBB+ 2013	Health care system A- 2013
Selected financial statistics						
Inpatient admissions	8,347	34,917	37,798	40,121	MNR	MNR
Emergency visits	45,588	170,331	183,378	208,013	MNR	MNR
Inpatient surgeries	2,353	9,430	9,101	9,418	MNR	MNR
Outpatient surgeries	6,442	24,896	25,118	26,839	MNR	MNR
Based on net/gross revenues	Gross	Gross	Gross	Gross	MNR	MNR
Medicare %	54.4	54.3	53.2	52.9	MNR	MNR
Medicaid %	10.9	11.1	11.5	11.4	MNR	MNR
Commercial/blues %	28.7	27.7	24.8	25.3	MNR	MNR
Financial profile						
Financial performance						
Net patient revenue ($000s)	198,716	743,266	754,488	741,822	1,049,981	1,567,503
Total operating revenue ($000s)	204,521	772,707	798,223	789,726	MNR	MNR
Total operating expenses ($000s)	200,040	769,403	786,507	769,073	MNR	MNR
Operating income ($000s)	4,481	3,304	11,716	20,653	MNR	MNR
Operating margin (%)	2.19	0.43	1.47	2.62	0.90	1.50
Net nonoperating income ($000s)	3,554	14,749	17,300	17,360	MNR	MNR
Excess income ($000s)	8,035	18,053	29,016	38,013	MNR	MNR
Excess margin (%)	3.86	2.29	3.56	4.71	3.00	3.60
Operating EBIDA margin (%)	11.59	9.28	10.63	11.24	8.90	8.40
EBIDA margin (%)	13.10	10.98	12.53	13.15	10.20	9.50

Wellmont Health System (cont.)						
Net available for debt service ($000s)	27,248	86,461	102,241	106,093	115,667	166,108
Maximum annual debt service ($000s)	42,797	42,797	42,797	42,797	MNR	MNR
Maximum annual debt service coverage (x)	2.55	2.02	2.39	2.48	2.50	3.40
Operating lease-adjusted coverage (x)	2.55	1.75	1.97	2.02	2.10	2.60
Liquidity and financial flexibility						
Unrestricted reserves ($000s)	430,895	447,156	426,182	379,544	574,523	761,463
Unrestricted days' cash on hand	211.8	226.9	211.6	191.7	144.60	163.90
Unrestricted reserves/total long-term debt (%)	89.3	91.2	89.5	82.6	106.70	119.60
Average age of plant (years)	N.A.	12.5	11.2	11.4	11.50	11.40
Capital expenditures/depreciation and amortization (%)	36.0	173.6	112.4	99.2	114.10	124.60
Debt and liabilities						
Total long-term debt ($000s)	482,617	490,443	475,946	459,654	MNR	MNR
Long-term debt/capitalization (%)	47.2	47.5	48.4	49.9	46.20	42.50
Debt burden (%)	5.14	5.43	5.23	5.30	3.00	2.70
Defined benefit plan funded status (%)	N.A.	80.39	79.52	68.03	80.20	79.90

MNR: Median not reported. N.A.: Not available. Note: Fiscal 2012 and 2013 patient volumes include Lee Regional, which as of Oct. 1, 2013, became a discontinued operation.

Related Criteria And Research

Related Criteria

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- USPF Criteria: Commercial Paper, VRDO, And Self-Liquidity, July 3, 2007
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012
- General Criteria: Methodology: Industry Risk, Nov. 20, 2013

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Outlook Remains Negative Despite A Glimmer Of Relief , Dec. 17, 2014
- U.S. Not-For-Profit Health Care System Ratios: Operating Performance Weakened In 2013, Aug. 13, 2014
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- Standard & Poor's Assigns Industry Risk Assessments To 38 Nonfinancial Corporate Industries, Nov. 20, 2013
- Alternative Financing: Disclosure Is Critical To Credit Analysis In Public Finance, Feb. 18, 2014
- Health Care Organizations See Integration And Greater Transparency As Prescriptions For Success, May 19, 2014

Ratings Detail (As Of February 4, 2015)

Sullivan Cnty Hlth Ed & Hsg Fac Brd, Tennessee

Wellmont Hlth Sys, Tennessee

Ser 2011

Long Term Rating	BBB+/Stable	Outlook Revised

Ratings Detail (As Of February 4, 2015) (cont.)		
Virginia Small Business Fin Auth, Virginia		
Wellmont Hlth Sys, Tennessee		
Ser 2007A		
Long Term Rating	BBB+/Stable	Outlook Revised

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Research

Bulletin:

Mountain States Health Alliance-Wellmont Health System Merger Does Not Affect Ratings

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DALLAS (Standard & Poor's) April 2, 2015--Standard & Poor's Ratings Services said today that Mountain States Health Alliance's (BBB+/Stable) and Wellmont Health System's (BBB+/Stable) agreement of intent to merge has no immediate effect on ratings. The proposed merger will be a true merger, with equal representation of board members, under a new name for the combined organization to be agreed upon at a later date. We understand that Wellmont and Mountain States will enter into due diligence with anticipated finalization of an agreement by the end of August 2015, completion of regulatory review within 90 days after that, and closing of the merger not later than Dec. 31, 2015.

Mountain States is a 13-hospital system with facilities in Tennessee and Virginia and more than 1,300 staffed acute-care beds along with numerous outpatient facilities. Wellmont is a six-hospital system with facilities in Tennessee and Virginia and operates more than 700 acute-care beds.

While details of the merger remain to be addressed, we understand that the two entities will likely combine their balance sheets and that both organizations are committed to reducing debt. In our view, the merged organization will likely have opportunities for cost reduction and other operating synergies, but at this point detailed benefits of the merger cannot be fully evaluated.

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We believe that it is likely the two systems will successfully reach a final agreement to merge and that any regulatory issues will be addressed. We are not taking rating action at this time.

Standard & Poor's will review and evaluate the merger integration plan and wait on a final agreement between Mountain States and Wellmont before forming a rating opinion later this year.

For more information on Wellmont Health System, please see our report published Feb. 4, 2015, on RatingsDirect. For more information on Mountain States Health Alliance, please see our report published Jan. 9, 2015.

Exhibit 11.6

The current annual budget for Mountain States is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

Exhibit 11.7

The current annual budget for Wellmont is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

Exhibit 11.8

Five Year Projected Budget for the New Health System

FTI Consulting ("FTI") was engaged by the Parties for the purpose of providing an independent and objective review focused on the identification and quantification of potential economies and efficiencies gained through the integration of Wellmont Health System (WHS) and Mountain States Health Alliance (MSHA). Through the development of a financial model (the "Financial Model"), FTI calculated baseline ("Baseline") financial statements for the combined New Health System. The "Baseline" financial statements served as the source for the creation of financial statements for the New Health System to demonstrate the expected impact of the identified synergies of the merger, the "Preliminary Efficiencies" financial statements.

The work completed by FTI was performed by members of FTI's Health Solutions Practice. This Practice consists of over 300 professionals including clinicians, healthcare executives, strategists, and functional specialists located in 27 offices across the United States. Many of FTI's Health Solutions executives have more than 25 years of experience leading health systems, hospitals, and physician organizations; designing and implementing enhanced performance programs; and performing complex healthcare operational and financial analyses. In performance of our work, FTI utilized processes, procedures and methodologies consistent with merger, affiliation and cost efficiency work that we have performed for other healthcare clients. The FTI Team included one member who was involved in the Memorial Mission Hospital/St. Joseph's Hospital COPA development in 1995. FTI created the Financial Model in accordance with Generally Accepted Accounting Principles ("GAAP").

Financial Model

Creation of the Financial Model. The "Baseline" Financial Model portrays the combined operations of the Parties primarily utilizing information contained within the audited financial statements as well as other publicly available data. This financial information is referred to as the "Baseline" financials or the (A + B = C) financial statements. Out of an abundance of caution, FTI worked under a Black Box agreement and established a "Black Box Team" in order to be able to review and take into consideration information that could be deemed proprietary and confidential in creating the assumptions that underpin the projections in our Financial Model.

The "Preliminary Efficiencies" financial statements for the New Health System in FTI's financial model reflect the impacts from the potential efficiency savings to be derived from the synergies identified as well as the expenditures related to the intended uses of efficiency savings for the public benefit as determined by the Parties. The"Preliminary Efficiencies" financial statements are built off of the "Baseline" financial statements. These statements are intended to represent the financial impacts to the New Health System as the result of achieving the identified efficiency savings and investing in the new public benefit initiatives.

In creating both the "Baseline" and "Preliminary Efficiencies" financial statements, the FTI "Clean Team" members considered, but did not directly incorporate in an identifiable way, specific financial information provided by each individual organization in their business plans, projections, or any other source of information that was deemed to be confidential or proprietary given the competitive environment in which the Parties currently operate. All assumptions related to projections in pricing, volume, costs, and other income and expenses are based on the Parties' combined historical performance, adjusted by FTI's understanding of the health care provider industry and experience in developing financial forecasting models. Certain financial line items have been consolidated, blended or otherwise adjusted to protect the confidentiality of proprietary information, where applicable.

Both the "Baseline" and "Preliminary Efficiencies" financials include an income statement, balance sheet, and a statement of cash flows. In addition to those schedules, FTI created (1) debt schedules, and (2) PP&E and Capital Expenditures schedules. These schedules calculate certain balance sheet accounts that are dependent on income statement accounts and other investing or financing activities that are not reflected on the face of the income statement.

Timing and Phases of Efficiency Assumptions. During discussions with the Parties' Management teams, FTI validated "phase in" periods separately for each of the efficiencies savings from "Non-Labor", "Labor" and "Clinical" work areas. No efficiency savings are projected to be implemented in whole or in part until the FYE 6/17, and timing varies based on the agreed upon ability to successfully implement each individual opportunity.

"Baseline Model" – Income Statement. In the points enumerated below, we delineate the key drivers and/or assumptions used in the Baseline Financial Model for the preparation of a combined New Health System Income Statement. The assumptions apply general industry expectations in accordance with historical performance, and do not include any known or anticipated changes in operations for the individual hospitals that would be deemed to be proprietary or confidential in a manner that would allow either Party's proprietary or confidential information to be calculated.

- **Revenue.** The key drivers for this account are service volume and reimbursement rates, which are built into the model as percentage changes and applied to the prior year volume and reimbursement rates. Service volume is based on adjusted patient days ("APD") and reimbursement rates utilize net patient service revenue ("NPSR") per APD as the proxy for reimbursement rates. Revenue includes the revenue related to Joint Ventures ("JVs") that are consolidated for financial reporting purposes. The net income attributable to the JVs is eliminated in the "Other non-operating items" line in the income statement. The service volume assumptions in the model account for an initial decrease in service volume related to changes in utilization based on industry trends. The later periods reflect consistent service volume based COPA commitments to maintain/expand locations and services currently available to the community. The model assumption for NPSR per APD includes an annual increase of 2.0%.

- **Other Revenues.** The model assumes other revenues remain flat each year over the 5-year forecasted period.
- **Salaries, Wages, & Benefits.** The key drivers for this expense are total paid full-time equivalents ("FTEs") and average salaries, wages, & benefits (SW&B) per paid FTE. The total paid FTEs is a function of service volume, which is related to APDs; however, the assumption does not include a proportionate decline in paid FTEs and APDs. Since a portion of the staff is corporate overhead and would not necessarily increase or decrease with service volume, FTI reduced the change in FTE's by 15% of the change in volume (e.g., if patient volume decreased by 2%, then paid FTEs would only decrease by 1.7%). Additionally, there is an independent assumption that applies a percentage change to the prior period average SW&B per paid FTE to calculate the current period SW&B per paid FTE. The total salaries, wages, & benefits is the product of the current period paid FTEs and the current period average SW&B per paid FTE. The model assumption for SW&B per paid FTE is an annual increase of 3.0%.
- **Medical Supplies & Drugs.** The key drivers for these expenses are service volume and product costs. The financial model calculates the average medical supplies & drugs cost per APD from the base period. Then the model incorporates a cost increase from prior period to the current period for the average medical supplies & drugs cost per APD. The total "medical supplies & drugs" expense is the product of the current period medical supplies & drugs cost per APD and the service volume (e.g., APD). The model assumption for the percentage change is an annual increase of 2.5%.
- **Purchased Services Assumption.** The model assumption applies a percentage change to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 3.0%.
- **Interest & Taxes.** The model uses a blended interest rate of 4.0% derived from the historical experience of the Parties. The outstanding long-term debt balance used in the model is described in the "Baseline Debt Schedule" of this document. The model does not include an input for taxes due to their immaterial nature to the Parties historically.
- **Depreciation & Amortization.** The key drivers are rate of depreciation & amortization, asset disposals, and capital expenditures. The primary assumptions that impact these expenses are capital expenditures and the useful life of property, plant, and equipment ("PP&E"). This represents a non-cash expense and is primarily a function of the PP&E on New Health System's balance sheet.
- **Maintenance & Utilities.** The model applies a percentage change to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 3.0%.
- **Lease & Rental.** The model applies a percentage change to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 2.5%.

- **Other Expenses.** The model applies a percentage change to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 4.0%.
- **Investment Income.** The key drivers are the rate of return on investments and the long-term investments amount on the balance sheet. The total investment income is the product of the rate of return and the long-term investments balance. The model assumes that investment income is rolled into the long-term investment balance at the end of the fiscal year. The model assumption for the interest income is an annual increase of 2.0%.
- **Derivative Valuation Adjustments.** This expense represents an event driven scenario that would produce a non-cash expense. The user of the financial model may manually change this amount given such an event is known; however, the model, as constructed by FTI, does not contemplate such an event.
- **Loss on Refinancing.** This expense represents an event driven scenario that would produce a non-cash expense. The user of the financial model may manually change this amount given such an event is known; however, the model, as constructed by FTI, does not contemplate such an event.
- **Gain on Revaluation of Equity Method Investment.** This expense represents an event driven scenario that would produce a non-cash expense. The user of the financial model may manually change this amount given such an event is known; however, the model, as constructed by FTI, does not contemplate such an event.
- **Discontinued Operations.** This expense represents an event driven scenario that attempts to present financial statements net of the impact from discontinued segments of operations. The user of the financial model may manually change this amount given such an event is known or expected; however, the model, as constructed by FTI, does not contemplate such an event.
- **Income Attributable to Non-Controlling Interest.** MSHA owns a majority interest in three hospital facilities. The total amounts of revenues, expenses, gains, losses and net income attributed to these facilities is included in the "Income Statement" in the appropriate line item classification. The amount of income attributable to the non-controlling interest (minority interest) is reported as "Income attributable to non-controlling interest" in the "Other non-operating section" of the "Income Statement".

"Baseline Model"– Balance Sheet. In the points enumerated below, FTI delineates the key drivers and/or assumptions used in the Baseline Financial Model for a combined New Health System Balance Sheet. These assumptions apply general health care industry assumptions to the Parties' combined historical performance and do not include any known or anticipated changes in operations for the individual hospitals that would be deemed to be proprietary or confidential.

- **Cash & Cash Equivalents.** The balance for this asset account is a function of operations, changes in various balance sheet, etc. The "cash & cash equivalents" is calculated on the "Baseline Cash Flow Statement".
- **Current Portion of Investments.** This asset account is subject to the duration and timing of when long-term investments reach the end of their stated investment period. Although this may vary significantly from period to period based on the New Health System's investment strategy, FTI incorporated a model assumption that the current portion of investments remains flat each year over the 5-year forecasted period.
- **Patients Accounts Receivable, Net.** This asset account is a function of NPSR from the income statement and a model assumption that estimates average payor payment terms as days sales outstanding ("DSO"). The balance is the product of the average daily NPSR for the current period and the DSO assumption. The model assumption for the DSO is 55.0 each year over the 5-year forecasted period.
- **Other Receivables, Net.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 5.0%.
- **Inventories & Prepaid Expenses.** This asset account is a function of "medical supplies & drugs" from the income statement and a model assumption that estimates average inventory & prepaid carrying amount called days inventory outstanding ("DIO"). The balance is the product of the average daily "medical supplies & drugs" expense for the current period and the DIO assumption. The model assumption for the DIO is 65.0 each year over the 5-year forecasted period.
- **Long-Term Investments.** This asset account is dependent on the assumptions related to "Investment Income" on the income statement. The model assumption related to this account is that all "Investment Income" is reinvested. Thus, the current period balance in the model is the summation of the prior period account balance and the current period "Investment Income". The model assumption for the interest income is an annual increase of 2.0%.
- **Property, Plant, & Equipment, Net.** This asset account is dependent on depreciation & amortization, asset disposals, and capital expenditures. The primary assumptions that impact these expenses are capital expenditures and the useful life of property, plant, and equipment ("PP&E"). The asset account is calculated on a separate schedule FTI prepared that includes our assumptions related to capital expenditures, asset disposals, and depreciation of assets.
- **Goodwill.** Changes in this account balance primarily relate to events such as acquisitions or impairment of prior acquisitions. The balance of this account may be changed manually, but the model, as constructed by FTI, assumes there are no changes in the goodwill balance.

- **Net Deferred Financing, Acquisition Costs & Other Charges.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual decrease of 5.0%.
- **Other Assets.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 3.0%.
- **Current Portion of Debt & Liabilities.** The model is built to be able to apply an independent percentage change assumption to the prior period amount to calculate the current period amount, if applicable. The model as built by FTI, however, assumes the current portion of debt and liabilities remains flat each year over the 5-year forecasted period.
- **Accounts Payable & Accrued Expenses.** This liability account is a function of certain operating expenses from the income statement and a model assumption that estimates average payment terms as days payables outstanding ("DPO"). The balance is the product of the average daily operating expense for the current period and the DPO assumption. The model assumption for the DPO is 60.0 each year over the 5-year forecasted period.
- **Estimated Third-Party Payor Settlements.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 2.0%.
- **Long-Term Debt & Liabilities.** The liability account is a function of the principal portion of debt service payments and any new financing or additional principal payments. The balance for this liability is calculated on the "Debt Schedule", which is discussed later in this section.
- **Retention Bonus Liability.** Since this is an event driven liability and would not likely occur unless an actual merger went into effect, FTI has not included any balance in this liability account for the "Baseline Balance Sheet" in the Baseline model. However, the "Preliminary Efficiencies" balance sheet does include a $5 million dollar liability for retention bonus liability at 6/30/17 related to the "Uses Expenses". The liability and remaining portion of the "Uses Expenses" is expected to be paid before 6/30/18.
- **Other Long-Term Liabilities.** The model applies an independent percentage change assumption to the prior period amount to calculate the current period amount. The model assumption for the percentage change is an annual increase of 2.0%.
- **Unrestricted (Net Assets).** This balance is a function of the prior period balance and the "Revenues & Gains in Excess of Expenses & Losses Attributable to the New Health System" on the income statement.

- **Temporarily Restricted (Net Assets).** Since this is an event driven allocation, FTI held this balance flat for each forecasted period and allocated the change in net assets from operations to the "Unrestricted" and the "Non-Controlling Interests" accounts.
- **Permanently Restricted (Net Assets).** Since this is an event driven allocation, FTI held this balance flat for each forecasted period and allocated the change in net assets from operations to the "Unrestricted" and the "Non-Controlling Interests" accounts.
- **Non-Controlling Interests (Net Assets).** MSHA owns a majority interest in three hospital facilities. The non-controlling interest (minority interest) is the portion of equity (net assets) not attributable directly to the majority owner. The non-controlling interest is shown as "Non-controlling interest" in the net assets section of the "Balance Sheet".

"Preliminary Efficiencies Financial Model"– Functionality & Assumptions. The "Preliminary Efficiencies Financial Model" tabs include the assumptions and results from the "Baseline Income Statement & Balance Sheet" tabs and layers in the anticipated savings from: (1) Non-Labor Efficiencies; (2) Labor Efficiencies; and (3) Clinical Efficiencies. The estimated savings assumptions were presented to and discussed with Management from both Parties and with the Integration Council as well as the "Joint Board Task Force". Additionally, the "Preliminary Efficiencies Financial Model" includes an additional line item for "Uses expenses related to COPA, excluding D&A expenses" ("Uses Expense") which includes the estimated expenses related to combination of the hospital systems, COPA compliance costs, and costs associated with providing additional benefits and services to the community. The Uses Expenses were provided by the Integration Council. In FTI's financial model, the "Preliminary Efficiencies Financial Model" tabs reflect the same assumptions and results as the "Baseline Income Statement & Balance Sheet" tabs previously described, unless modifications to certain assumptions are made by the user, such as the examples provided below.

- **PP&E and Capital Expenditures Schedule.** The "depreciation and amortization expense" and "capital expenditures" may differ from the "Baseline Financial Model" if the user modifies the assumptions within the "PP&E and CapEx schedules" on the "Preliminary Efficiencies" tabs to reflect different decisions or scenarios than those included in the "Baseline Financial Model". Changes made directly to this schedule within the "Preliminary Efficiencies" model flow directly into the "Preliminary Efficiencies" financial statements, but not into the Baseline financial statements and vice versa, as the "Baseline" and "Preliminary Efficiencies" financial statements operate independently of one another.
- **Debt Schedule.** As is the case with the PP&E and Capital Expenditures Schedules, as described above, the interest expense for this schedule may differ from the "Baseline Income Statement" if certain assumptions within "Preliminary Efficiencies" tabs are modified, since the assumptions within the "Preliminary Efficiencies" financial statements are built and operate independently of the "Baseline" financial statements.

"Baseline" Financial Model Income Statement

Income Statement - NewCo Baseline	Actuals			Forecasted				
$'000s	FYE 6/13	FYE 6/14	FYE 6/15	FYE 6/16	FYE 6/17	FYE 6/18	FYE 6/19	FYE 6/20
Net patient service revenue ("NPSR")	**$ 1,670,727**	**$ 1,671,050**	**$ 1,813,472**	**$ 1,812,747**	**$ 1,886,737**	**$ 1,924,471**	**$ 1,962,961**	**$ 2,002,220**
Other revenues:								
Other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total other revenues	**120,585**	**102,581**	**90,756**	**90,756**	**90,756**	**90,756**	**90,756**	**90,756**
Total revenue, gains, & support	**1,791,312**	**1,773,631**	**1,904,228**	**1,903,502**	**1,977,492**	**2,015,227**	**2,053,716**	**2,092,976**
Expenses:								
Salaries, wages, & benefits	881,530	865,989	925,061	936,615	948,313	960,157	972,150	984,292
Medical supplies & drugs	325,559	330,375	344,718	346,269	362,169	371,224	380,504	390,017
Purchased services	183,607	189,280	196,037	201,918	207,975	214,215	220,641	227,260
Interest & taxes	63,495	62,742	61,453	60,964	59,338	57,756	56,216	54,717
Depreciation & amortization	130,666	121,237	127,336	126,507	126,364	126,828	127,872	129,471
Maintenance & utilities	53,687	54,030	56,561	58,258	60,006	61,806	63,660	65,570
Lease & rental	17,892	15,506	15,435	15,821	16,216	16,622	17,037	17,463
Other	107,995	122,584	143,924	149,681	155,668	161,895	168,371	175,105
Total expenses & losses	**1,764,431**	**1,761,743**	**1,870,524**	**1,896,033**	**1,936,050**	**1,970,502**	**2,006,451**	**2,043,895**
Income from operations	**26,881**	**11,888**	**33,704**	**7,470**	**41,442**	**44,724**	**47,266**	**49,080**
Non-operating gains:								
Investment income	60,296	65,452	4,883	23,099	23,561	24,032	24,512	25,003
Derivative valuation adjustments	9,474	4,526	19,093	-	-	-	-	-
Loss on refinancing	-	(5,755)	(1,389)	-	-	-	-	-
Gain on revaluation of equity method investment	-	14,744	-	-	-	-	-	-
Non-operating gains, net	**69,770**	**78,967**	**22,587**	**23,099**	**23,561**	**24,032**	**24,512**	**25,003**
Revenues & gains in excess of expenses & losses	**96,651**	**90,855**	**56,291**	**30,568**	**65,002**	**68,756**	**71,778**	**74,083**
Other non-operating items:								
Discontinued operations	(4,484)	(26,639)	(2,720)	-	-	-	-	-
Income attributable to non-controlling interest	(7,728)	(9,826)	(15,046)	(14,459)	(14,975)	(15,031)	(15,077)	(15,111)
Total other non-operating operations	**(12,212)**	**(36,465)**	**(17,765)**	**(14,459)**	**(14,975)**	**(15,031)**	**(15,077)**	**(15,111)**
Revenues & gains in excess of expenses & losses attributable to NewCo	**$ 84,439**	**$ 54,390**	**$ 38,526**	**$ 16,110**	**$ 50,027**	**$ 53,725**	**$ 56,701**	**$ 58,972**

"Baseline" Financial Model Balance Sheet

Balance Sheet - NewCo Baseline	Actuals			Forecasted				
$'000s	6/30/13	6/30/14	6/30/15	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20
Current assets:								
Cash & cash equivalents	$ 130,860	$ 89,859	$ 128,580	$ 98,369	$ 87,482	$ 80,297	$ 70,623	$ 57,914
Current portion of investments	25,447	28,262	22,904	22,904	22,904	22,904	22,904	22,904
Patient accounts receivable, net	271,216	278,583	274,678	273,154	284,303	289,989	295,789	301,704
Other receivables, net	51,463	60,187	41,588	43,667	45,851	48,143	50,551	53,078
Inventories & prepaid expenses	58,383	59,859	63,930	61,664	64,496	66,108	67,761	69,455
Total current assets	**537,370**	**516,750**	**531,680**	**499,758**	**505,035**	**507,442**	**507,628**	**505,056**
Other non-current assets:								
Long-term investments	1,037,563	1,124,957	1,154,927	1,178,026	1,201,586	1,225,618	1,250,131	1,275,133
Property, plant, & equipment, net	1,359,023	1,374,010	1,331,657	1,330,150	1,335,035	1,346,020	1,362,851	1,385,318
Goodwill	169,487	208,262	208,179	208,179	208,179	208,179	208,179	208,179
Net deferred financing, acquisition costs & other charges	33,658	30,067	28,972	27,523	26,147	24,840	23,598	22,418
Other assets	47,091	48,870	53,567	55,174	56,830	58,534	60,290	62,099
Total other non-current assets	**2,646,822**	**2,786,166**	**2,777,303**	**2,799,052**	**2,827,778**	**2,863,191**	**2,905,049**	**2,953,148**
Total assets	**3,184,192**	**3,302,916**	**3,308,983**	**3,298,811**	**3,332,813**	**3,370,633**	**3,412,676**	**3,458,204**
Current liabilities:								
Current portion of debt & liabilities	75,323	73,791	84,731	84,731	84,731	84,731	84,731	84,731
Accounts payable & accrued expenses	242,267	261,554	270,782	268,682	275,199	280,683	286,301	292,056
Estimated third-party payor settlements	33,932	18,888	18,471	18,841	19,217	19,602	19,994	20,394
Total current liabilities	**351,523**	**354,233**	**373,985**	**372,254**	**379,148**	**385,017**	**391,027**	**397,181**
Non-current liabilities:								
Long-term debt & liabilities	1,566,294	1,565,512	1,524,098	1,483,455	1,443,897	1,405,393	1,367,915	1,331,438
Retention bonus liability	-	-	-	-	-	-	-	-
Other long-term liabilities	78,447	99,400	81,633	83,265	84,931	86,629	88,362	90,129
Total non-current liabilities	**1,644,740**	**1,664,912**	**1,605,731**	**1,566,721**	**1,528,827**	**1,492,022**	**1,456,277**	**1,421,567**
Total liabilities	**1,996,263**	**2,019,145**	**1,979,715**	**1,938,975**	**1,907,975**	**1,877,038**	**1,847,304**	**1,818,748**
Net assets:								
Unrestricted	994,348	1,080,586	1,112,232	1,128,342	1,178,369	1,232,094	1,288,796	1,347,767
Temporarily restricted	19,703	20,418	20,508	20,508	20,508	20,508	20,508	20,508
Permanently restricted	1,438	1,446	1,450	1,450	1,450	1,450	1,450	1,450
Noncontrolling interests	172,439	181,321	195,078	209,536	224,511	239,542	254,619	269,730
Total net assets	**1,187,929**	**1,283,771**	**1,329,268**	**1,359,836**	**1,424,838**	**1,493,594**	**1,565,372**	**1,639,456**
Total liabilities and net assets	**$ 3,184,192**	**$ 3,302,916**	**$ 3,308,983**	**$ 3,298,811**	**$ 3,332,813**	**$ 3,370,633**	**$ 3,412,676**	**$ 3,458,204**

"Baseline" Financial Model Statement of Cash Flows

Statement of Cash Flows - NewCo Baseline	Forecasted				
$'000s	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20
Cash flows from operating activities:					
Income from operations	$ 7,470	$ 41,442	$ 44,724	$ 47,266	$ 49,080
Adjustments to reconcile change in net assets to net cash provided by operating activities:					
Depreciation and amortization	126,507	126,364	126,828	127,872	129,471
Loss on extinguishment of debt	-	-	-	-	-
Change in estimated fair value of derivatives	-	-	-	-	-
Equity in net income of JVs, net	-	-	-	-	-
Loss/(Gain) on disposal of assets	-	-	-	-	-
Capital Appreciation Bond accretion and other	-	-	-	-	-
Restricted contributions	-	-	-	-	-
Pension and other defined benefit plan adjustments	-	-	-	-	-
Increase/(Decrease) in cash due to change in:					
Patient accounts receivable, net	1,524	(11,149)	(5,686)	(5,800)	(5,916)
Other receivables, net	(2,079)	(2,183)	(2,293)	(2,407)	(2,528)
Inventories & prepaid expenses	2,266	(2,832)	(1,612)	(1,653)	(1,694)
Net deferred financing, acquisition costs & other charges	1,449	1,376	1,307	1,242	1,180
Other assets	(1,607)	(1,655)	(1,705)	(1,756)	(1,809)
Current portion of debt & liabilities	-	-	-	-	-
Accounts payable & accrued expenses	(2,100)	6,517	5,485	5,618	5,755
Estimated third-party payor settlements	369	377	384	392	400
Other long-term liabilities	1,633	1,665	1,699	1,733	1,767
Total adjustments	**127,962**	**118,480**	**124,407**	**125,241**	**126,627**
Net cash provided by operating activities	**135,432**	**159,922**	**169,132**	**172,506**	**175,707**
Cash flows from investing activities:					
Purchases of property, plant, and equipment	(125,000)	(131,250)	(137,813)	(144,703)	(151,938)
Acquisitions, net of cash acquired	-	-	-	-	-
Non-operating gains, net	23,099	23,561	24,032	24,512	25,003
Purchases of held-to-maturity securities	(23,099)	(23,561)	(24,032)	(24,512)	(25,003)
Net distribution from JV's and unconsolidated affiliates	-	-	-	-	-
Proceeds from sale of plant, property, and equipment	-	-	-	-	-
Net cash used in investing activities	**(125,000)**	**(131,250)**	**(137,813)**	**(144,703)**	**(151,938)**
Cash flows from financing activities:					
Payments on LT debt and liabilities (net of interest)	(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Payment of acquisition and financing costs	-	-	-	-	-
Proceeds from issuance of LT debt & other financings	-	-	-	-	-
Net amounts received on interest rate swaps	-	-	-	-	-
Restricted contributions received	-	-	-	-	-
Net cash used by financing activities	**(40,643)**	**(39,559)**	**(38,504)**	**(37,477)**	**(36,478)**
Net increase/(decrease) in cash and cash equivalents	(30,211)	(10,887)	(7,185)	(9,674)	(12,709)
Cash and cash equivalents at beginning of year	128,580	98,369	87,482	80,297	70,623
Cash and cash equivalents at end of year	**$ 98,369**	**$ 87,482**	**$ 80,297**	**$ 70,623**	**$ 57,914**

New Health System "Preliminary Efficiencies" Financial Model Income Statement

Income Statement - NewCo with Preliminary Efficiency Estimates	Actuals			Forecasted				
$'000s	FYE 6/13	FYE 6/14	FYE 6/15	FYE 6/16	FYE 6/17	FYE 6/18	FYE 6/19	FYE 6/20
Net patient service revenue ("NPSR")	**$ 1,670,727**	**$ 1,671,050**	**$ 1,813,472**	**$ 1,812,747**	**$ 1,886,737**	**$ 1,924,471**	**$ 1,962,961**	**$ 2,002,220**
Other revenues:								
Other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total other revenues	**120,585**	**102,581**	**90,756**	**90,756**	**90,756**	**90,756**	**90,756**	**90,756**
Total revenue, gains, & support	**1,791,312**	**1,773,631**	**1,904,228**	**1,903,502**	**1,977,492**	**2,015,227**	**2,053,716**	**2,092,976**
Expenses:								
Salaries, wages, & benefits	881,530	865,989	925,061	936,615	943,313	946,284	933,869	944,905
Medical supplies & drugs	325,559	330,375	344,718	324,637	337,871	340,077	341,319	344,036
Purchased services	183,607	189,280	196,037	196,267	201,785	205,843	209,137	213,911
Interest & taxes	63,495	62,742	61,453	60,964	59,338	57,756	56,216	54,717
Depreciation & amortization	130,666	121,237	127,336	126,507	130,650	142,843	157,111	165,204
Maintenance & utilities	53,687	54,030	56,561	57,256	58,898	60,211	61,277	62,824
Lease & rental	17,892	15,506	15,435	15,821	16,216	16,551	16,795	17,200
Other	107,995	122,584	143,924	136,822	141,334	143,709	146,050	148,728
Total expenses & losses	**1,764,431**	**1,761,743**	**1,870,524**	**1,854,888**	**1,889,406**	**1,913,272**	**1,921,774**	**1,951,524**
Income from operations	**26,881**	**11,888**	**33,704**	**48,614**	**88,086**	**101,955**	**131,943**	**141,451**
Non-operating gains:								
Investment income	60,296	65,452	4,883	23,099	23,561	24,032	24,512	25,003
Derivative valuation adjustments	9,474	4,526	19,093	-	-	-	-	-
Loss on refinancing	-	(5,755)	(1,389)	-	-	-	-	-
Gain on revaluation of equity method investment	-	14,744	-	-	-	-	-	-
Non-operating gains, net	**69,770**	**78,967**	**22,587**	**23,099**	**23,561**	**24,032**	**24,512**	**25,003**
Revenues & gains in excess of expenses & losses	**96,651**	**90,855**	**56,291**	**71,713**	**111,647**	**125,986**	**156,455**	**166,454**
Other non-operating items:								
Discontinued operations	(4,484)	(26,639)	(2,720)	-	-	-	-	-
Income attributable to non-controlling interest	(7,728)	(9,826)	(15,046)	(14,459)	(14,975)	(15,031)	(15,077)	(15,111)
Total other non-operating operations	**(12,212)**	**(36,465)**	**(17,765)**	**(14,459)**	**(14,975)**	**(15,031)**	**(15,077)**	**(15,111)**
Revenues & gains in excess of expenses & losses attributable to NewCo.	**$ 84,439**	**$ 54,390**	**$ 38,526**	**$ 57,254**	**$ 96,672**	**$ 110,955**	**$ 141,378**	**$ 151,343**
Uses expense related to COPA, excluding D&A expense	-	-	-	-	(10,750)	(27,250)	(43,500)	(49,000)
Net income, including COPA uses attributable to NewCo.	**$ 84,439**	**$ 54,390**	**$ 38,526**	**$ 57,254**	**$ 85,922**	**$ 83,705**	**$ 97,878**	**$ 102,343**

New Health System "Preliminary Efficiencies" Financial Model Balance Sheet

Balance Sheet - NewCo with Preliminary Efficiency Estimates	Actuals			Forecasted				
$'000s	6/30/13	6/30/14	6/30/15	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20
Current assets:								
Cash & cash equivalents	$ 130,860	$ 89,859	$ 128,580	$ 128,907	$ 118,700	$ 73,698	$ 60,795	$ 88,289
Current portion of investments	25,447	28,262	22,904	22,904	22,904	22,904	22,904	22,904
Patient accounts receivable, net	271,216	278,583	274,678	273,154	284,303	289,989	295,789	301,704
Other receivables, net	51,463	60,187	41,588	43,667	45,851	48,143	50,551	53,078
Inventories & prepaid expenses	58,383	59,859	63,930	57,812	60,169	60,562	60,783	61,267
Total current assets	**537,370**	**516,750**	**531,680**	**526,444**	**531,926**	**495,296**	**490,821**	**527,242**
Other non-current assets:								
Long-term investments	1,037,563	1,124,957	1,154,927	1,178,026	1,201,586	1,225,618	1,250,131	1,275,133
Property, plant, & equipment, net	1,359,023	1,374,010	1,331,657	1,330,150	1,360,750	1,420,720	1,468,311	1,480,046
Goodwill	169,487	208,262	208,179	208,179	208,179	208,179	208,179	208,179
Net deferred financing, acquisition costs & other charges	33,658	30,067	28,972	27,523	26,147	24,840	23,598	22,418
Other assets	47,091	48,870	53,567	55,174	56,830	58,534	60,290	62,099
Total other non-current assets	**2,646,822**	**2,786,166**	**2,777,303**	**2,799,052**	**2,853,492**	**2,937,891**	**3,010,509**	**3,047,875**
Total assets	**3,184,192**	**3,302,916**	**3,308,983**	**3,325,497**	**3,385,418**	**3,433,187**	**3,501,330**	**3,575,117**
Current liabilities:								
Current portion of debt & liabilities	75,323	73,791	84,731	84,731	84,731	84,731	84,731	84,731
Accounts payable & accrued expenses	242,267	261,554	270,782	268,682	275,199	280,683	286,301	292,056
Estimated third-party payor settlements	33,932	18,888	18,471	18,841	19,217	19,602	19,994	20,394
Total current liabilities	**351,523**	**354,233**	**373,985**	**372,254**	**379,148**	**385,017**	**391,027**	**397,181**
Non-current liabilities:								
Long-term debt & liabilities	1,566,294	1,565,512	1,524,098	1,483,455	1,443,897	1,405,393	1,367,915	1,331,438
Retention bonus liability	-	-	-	-	5,000	-	-	-
Other long-term liabilities	78,447	99,400	81,633	83,265	84,931	86,629	88,362	90,129
Total non-current liabilities	**1,644,740**	**1,664,912**	**1,605,731**	**1,566,721**	**1,533,827**	**1,492,022**	**1,456,277**	**1,421,567**
Total liabilities	**1,996,263**	**2,019,145**	**1,979,715**	**1,938,975**	**1,912,975**	**1,877,038**	**1,847,304**	**1,818,748**
Net assets:								
Unrestricted	994,348	1,080,586	1,112,232	1,155,028	1,225,975	1,294,648	1,377,450	1,464,681
Temporarily restricted	19,703	20,418	20,508	20,508	20,508	20,508	20,508	20,508
Permanently restricted	1,438	1,446	1,450	1,450	1,450	1,450	1,450	1,450
Noncontrolling interests	172,439	181,321	195,078	209,536	224,511	239,542	254,619	269,730
Total net assets	**1,187,929**	**1,283,771**	**1,329,268**	**1,386,522**	**1,472,443**	**1,556,148**	**1,654,027**	**1,756,369**
Total liabilities and net assets	**$ 3,184,192**	**$ 3,302,916**	**$ 3,308,983**	**$ 3,325,497**	**$ 3,385,418**	**$ 3,433,187**	**$ 3,501,330**	**$ 3,575,117**

New Health System "Preliminary Efficiencies" Financial Model Statement of Cash Flows

Statement of Cash Flows with Preliminary Efficiencies Estimate			Forecasted		
$'000s	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20
Cash flows from operating activities:					
Income from operations	$ 48,614	$ 88,086	$ 101,955	$ 131,943	$ 141,451
Uses expense related to COPA, excluding D&A expense	-	(10,750)	(27,250)	(43,500)	(49,000)
	48,614	**77,336**	**74,705**	**88,443**	**92,451**
Adjustments to reconcile change in net assets to net cash provided by operating activities:					
Depreciation and amortization	126,507	130,650	142,843	157,111	165,204
Loss on extinguishment of debt	-	-	-	-	-
Change in estimated fair value of derivatives	-	-	-	-	-
Equity in net income of JVs, net	-	-	-	-	-
Loss/(Gain) on disposal of assets	-	-	-	-	-
Capital Appreciation Bond accretion and other	-	-	-	-	-
Restricted contributions	-	-	-	-	-
Pension and other defined benefit plan adjustments	-	-	-	-	-
Increase/(Decrease) in cash due to change in:					
Patient accounts receivable, net	1,524	(11,149)	(5,686)	(5,800)	(5,916)
Other receivables, net	(2,079)	(2,183)	(2,293)	(2,407)	(2,528)
Inventories & prepaid expenses	6,118	(2,357)	(393)	(221)	(484)
Net deferred financing, acquisition costs & other charges	1,449	1,376	1,307	1,242	1,180
Other assets	(1,607)	(1,655)	(1,705)	(1,756)	(1,809)
Current portion of debt & liabilities	-	-	-	-	-
Accounts payable & accrued expenses	(2,100)	6,517	5,485	5,618	5,755
Estimated third-party payor settlements	369	377	384	392	400
Retention bonus liability	-	5,000	(5,000)	-	-
Other long-term liabilities	1,633	1,665	1,699	1,733	1,767
Total adjustments	**131,814**	**128,240**	**136,641**	**155,911**	**163,570**
Net cash provided by operating activities	**180,428**	**205,577**	**211,346**	**244,354**	**256,022**
Cash flows from investing activities:					
Purchases of property, plant, and equipment	(125,000)	(161,250)	(202,813)	(204,703)	(176,938)
Acquisitions, net of cash acquired	-	-	-	-	-
Non-operating gains, net	23,099	23,561	24,032	24,512	25,003
Purchases of held-to-maturity securities	(23,099)	(23,561)	(24,032)	(24,512)	(25,003)
Net distribution from JV's and unconsolidated affiliates	-	-	-	-	-
Proceeds from sale of plant, property, and equipment	-	-	-	-	-
Net cash used in investing activities	**(125,000)**	**(161,250)**	**(202,813)**	**(204,703)**	**(176,938)**
Cash flows from financing activities:					
Payments on LT debt and liabilities (net of interest)	(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Payment of acquisition and financing costs	-	-	-	-	-
Proceeds from issuance of LT debt & other financings	-	-	-	-	-
Income attributable to non-controlling interest	(14,459)	(14,975)	(15,031)	(15,077)	(15,111)
Net amounts received on interest rate swaps	-	-	-	-	-
Restricted contributions received	-	-	-	-	-
Net cash used by financing activities	**(55,101)**	**(54,534)**	**(53,535)**	**(52,554)**	**(51,589)**
Net increase/(decrease) in cash and cash equivalents	327	(10,207)	(45,002)	(12,903)	27,494
Cash and cash equivalents at beginning of year	128,580	128,907	118,700	73,698	60,795
Cash and cash equivalents at end of year	**$ 128,907**	**$ 118,700**	**$ 73,698**	**$ 60,795**	**$ 88,289**

Exhibit 11.9

Insurance Contracts and Payor Agreements in Place at the Time of the Application

Mountain States Health Alliance

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA001	Amendment (to Hospital Services Agreement)	Aetna Health Inc.	Mountain States Health Alliance - KDS & ETASC
MSHA002	2009VAAetnaContract – Physician Group Agreement	Aetna Health Inc.	Mountain States Health Alliance d/b/a Russell County Medical Center; Dickenson Community Hospital; Smyth County Community Hospital ; North Community Physician Services, LLC and Blue Ridge Medical Management Corporation
MSHA003	PHO Participation Agreement	Aetna Health Management, Inc.	NHC
MSHA004	Hospital Services Agreement	Aetna Health, Inc.	Norton Community Hospital
MSHA005	Hospital Services Agreement/Access Agreement	Aetna Health, Inc.	Mountain States Health Alliance
MSHA006	Amendment of Current Agreements	Aetna Health, Inc.	Mountain States Health Alliance
MSHA007	Hospital Services Agreement	Aetna Health, Inc.	Russell County Medical Center
MSHA008	Hospital Services Agreement	Aetna Health, Inc.	Smyth County Community Hospital
MSHA009	Hospital Services Agreement	Aetna Health, Inc.	Unicoi County Memorial Hospital
MSHA0010	Specialist Physician Contract; Access Agreement	Aetna Health, Inc.; Aetna Life Insurance	Individual contracts with each TN physician
MSHA0011	Preferred Provider Agreement	Align Networks, Inc.	Mountain States Health Alliance
MSHA0012	Network-Payor Agreement	Allied National, Inc.	Mountain States Managed Care, Inc.

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0013	Integrated Solutions Health Network, LLC Amerigroup Virginia, Inc. d/b/a AMERIGROUP Community Care Letter of Agreement (Plus Amendments	Amerigroup Virginia, Inc.	ISHN, LLC
MSHA0014	Medicare Medicaid Dual Integration Participation Attachment to the Provider Agreement	Anthem Health Plans of Virginia, Inc.	Mountain States Health Alliance – Abingdon Physician Partners; Blue Ridge Medical Management; Dickenson Community Hospital Physicians; Johnston Memorial Hospital Physicians; Russell County Medical Center Physicians; Norton Community Physician Services; Smyth County Community Hospital Physicians; Emmaus Community Healthcare, LLC D/B/A Piney Flats Urgent Care; Johnson County Family Medicine
MSHA0015	Anthem Blue Cross and Blue Shield Facility Agreement	Anthem Health Plans of Virginia, Inc.	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
MSHA0016	Amendment to the Anthem Blue Cross and Blue Shield Facility Agreement	Anthem Health Plans of Virginia, Inc.	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0017	Medicare Medicaid Dual Integration Participation Attachment to the Provider Agreement	Anthem Health Plans of Virginia, Inc.	Abingdon Physician Partners; Blue Ridge Medical Management; Dickenson Community Hospital Physicians; Johnston Memorial Hospital Physicians; Russell County Medical Center Physicians; Norton Community Physician Services; Smyth County Community Hospital Physicians; Emmaus Community Healthcare, LLC, d/b/a Piney Flats Urgent Care; Jonson County Family Medicine
MSHA0018	Medicare Medicaid Dual Integration Participation Attachment to the Medical Equipment Provider Agreement	Anthem Health Plans of Virginia, Inc.	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
MSHA0019	Medicare Medicaid Dual Integration Participation Attachment to the Anthem Blue Cross and Blue Shield Medical Equipment Provider Agreement	Anthem Health Plans of Virginia, Inc.	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
MSHA0020	Anthem Blue Cross and Blue Shield Provider Agreement – Behavioral Health – EC 453B	Anthem Health Plans of Virginia, Inc.	MSMG
MSHA0021	Anthem Blue Cross and Blue Shield Provider Agreement – Primary Care Physician – EC 104A	Anthem Health Plans of Virginia, Inc.	MSMG
MSHA0022	Anthem Blue Cross and Blue Shield Provider Agreement – Specialist EC 303	Anthem Health Plans of Virginia, Inc.	MSMG
MSHA0023	Anthem Blue Cross and Blue Shield Provider Agreement (Reference DME)	Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Just identifies party as Provider, no signature page attached, cannot identify the contracting party

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0024	Anthem Blue Cross and Blue Shield Facility Agreement – Non-Acute	Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
MSHA0025	HMO Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Facility Agreement – Non-Acute	Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
MSHA0026	Medicare Advantage Participation Attachment to the Anthem Blue Cross and Blue Shield Facility Agreement – Non-Acute	Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
MSHA0027	Provider Agreement	Appalachian Agency for Senior Citizens	Dickenson Community Hospital
MSHA0028	Provider Agreement	Appalachian Agency for Senior Citizens	Norton Community Hospital
MSHA0029	Provider Agreement	Appalachian Agency for Senior Citizens	Norton Community Physician Services Corporation
MSHA0030	Provider Agreement	Appalachian Agency for Senior Citizens	Mountain States Health Alliance dba Russell County Medical Center
MSHA0031	Provider Agreement	Appalachian Agency for Senior Citizens	Russell County Medical Center dba Riverside Community Medical Clinic
MSHA0032	AllCare for Seniors Provider Agreement	Appalachian Agency for Senior Citizens	Mountain States Health Alliance d/b/a Dickenson Community Hospital
MSHA0033	Provider Agreement and First Amendment to Provider Agreement	Appalachian Agency for Senior Citizens	Southwest Virginia Health Network, Inc.

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0034	AllCare for Seniors Provider Agreement	Appalachian Agency for Senior Citizens	Mountain States Health Alliance d/b/a Russell County Medical Center
MSHA0035	First Amendment to Provider Agreement	Appalachian Agency for Senior Citizens, Inc. (AllCare)	Mountain States Health Alliance d/b/a Russell County Medical Center
MSHA0036	Payor Agreement	Beech Street Corporation	Mountain States Managed Care, Inc.
MSHA0037	Payor Agreement	Beech Street Corporation	Mountain States Managed Care, Inc.
MSHA0038	Physician Hospital Organization Agreement (plus Amendment dated same date)	Beech Street Corporation	Mountain States Managed Care, Inc.
MSHA0039	Addendum to Payor Agreement	Beech Street Corporation	Mountain States Managed Care, Inc.
MSHA0040	Managed Care Administrative Services Agreement	Benefit Plan Administrators, Inc.	Smyth County Community Hospital
MSHA0041	Amendment to Managed Care Administrative Services Agreement	Benefit Plan Administrators, Inc.	Smyth County Community Hospital
MSHA0042	Participating Hospital Agreement	Benefit Resources, Inc.	Russell County Medical Center
MSHA0043	Group Practice Agreement (and Amendment)	Blue Cross Blue Shield of Tennessee, Inc.	Blue Ridge Medical Management Corporation
MSHA0044	Medicare Advantage Provider Agreement	Blue Cross Blue Shield of Tennessee, Inc.	Blue Ridge Medical Management Corporation
MSHA0045	Medicare Advantage Provider Agreement	Blue Cross Blue Shield of Tennessee, Inc.	Mountain States Health Alliance (Johnson City Medical Center; Sycamore Shoals Hospital; Indian Path Medical Center; North Side Hospital; Johnson City Specialty Hospital; Johnson County Health Center; Franklin Transitional Care; Princeton Transitional Care; Indian Path Transitional Care)
MSHA0046	Purchase Order	Blue Ridge Job Corp Center	Smyth County Community Hospital

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0047	Amendment 8 to the Bluepreferred Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Kingsport Ambulatory Surgery Center and East Tennessee Ambulatory Surgery Center
MSHA0048	Amendment 8 to the BlueSelect Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Kingsport Ambulatory Surgery Center and East Tennessee Ambulatory Surgery Center
MSHA0049	Amendment 8 to the Network P Hospice Attachment of the BlueCross BlueShield of Tennessee Medical Services Supplier Agreement	BlueCross BlueShield of Tennessee Inc.	Medical Center Hospice
MSHA0050	Amendment 5 to the Network P Skilled Nursing Facility Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Indian Path Medical Center Transitional Care Center and Princeton Transitional Care Center
MSHA0051	Amendment 5 to the Network S Skilled Nursing Facility Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Indian Path Medical Center Transitional Care Center and Princeton Transitional Care Center
MSHA0052	Dual Eligible Special Needs Plan Amendment to the Bluecare/Tenncare Select Attachment	BlueCross BlueShield of Tennessee Inc.	Participating TennCare Provider (BRMMC PCP)
MSHA0053	Dual Eligible Special Needs Plan Amendment to the Bluecare/Tenncare Select Attachment	BlueCross BlueShield of Tennessee Inc.	Participating TennCare Provider (BRMMC Specialist)
MSHA0054	Dual Eligible Special Needs Plan Amendment to the Bluecare/Tenncare Select Attachment	BlueCross BlueShield of Tennessee Inc.	Participating TennCare Provider (Facilities)

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0055	Blue Advantage Local PPO Medicare Advantage Provider Agreement Ambulatory Surgery Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Kingsport Ambulatory Surgery Center
MSHA0056	Blue Advantage Local PPO Durable Medical Equipment Attachment to the Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee Inc.	HealthPlus Pharmacy- DME
MSHA0057	BlueAdvantage Local PPO Medicare Advantage Provider Agreement Skilled Nursing Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Franklin Transitional Care, Princeton Transitional Care and Indian Path Transitional Care
MSHA0058	Amendment 1 to the BlueAdvantage Local PPO Medicare Advantage Provider Agreement Skilled Nursing Facility Attachment	BlueCross BlueShield of Tennessee Inc.	Mountain States Health Alliance for Franklin Transitional Care, Princeton Transitional Care and Indian Path Transitional Care
MSHA0059	BlueCare Network Attachment	BlueCross BlueShield of Tennessee Inc. and Volunteer State Health Plan, Inc. (VSHP)	Mediserve Medical Equipment of Kingsport, Wilson Pharmacy dba Healthplus and Pharmacy
MSHA0060	Amended and Restated BlueCross BlueShield of Tennessee Institution Agreement (plus Amendments effective same day)	BlueCross BlueShield of Tennessee, Inc.	Mountain States Health Alliance (Johnson City, Sycamore Shoals, Indian Path, Johnson County, Franklin Woods, Unicoi County, Kingsport Ambulatory, East Tennessee Ambulatory, Indian Path Med Center, Princeton Transitional)
MSHA0061	Rate Adjustments	BlueCross BlueShield of Tennessee, Inc.	Mountain States Health Alliance (Johnson City, Sycamore Shoals, Indian Path, Johnson County, Franklin Woods, Unicoi County, Kingsport Ambulatory, East Tennessee Ambulatory, Indian Path Med Center, Princeton Transitional)

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0062	Dual Eligible Special Needs Plan Amendment to BlueCare/Tenncare Select Attachment	BlueCross BlueShield of Tennessee, Inc.	Not listed
MSHA0063	Medicare Advantage Provider Agreement (plus Amendment)	BlueCross BlueShield of Tennessee, Inc.	Mountain States Health Alliance (Johnson City, Sycamore Shoats, Indian Path, North Side, Johnson City Specialty, Johnson County Health, Franklin Transitional, Princeton Transitional, Indian Path Transitional)
MSHA0064	BCBS of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc.	(Mountain States Health Alliance) Johnston Memorial Hospital
MSHA0065	Behavioral Health Amendment to the BLUECARE Institution Attachment	BlueCross BlueShield of Tennessee, Inc.	Mountain States Health Alliance (unclear which entity – likely Johnston Memorial Hospital)
MSHA0066	BlueCare Institution Agreement	BlueCross BlueShield of Tennessee, Inc.	All MSHA TN Facilities
MSHA0067	Bluegrass Family Health, Inc. Hospital Participation Agreement	Bluegrass Family Health, Inc.	Unicoi County Memorial Hospital
MSHA0068	CareCentrix Provider Agreement	CareCentrix	Mountain States Health Alliance dba MCHC
MSHA0069	Network Participating Facility Agreement	CHA Provider Network, Inc.	Norton Community Hospital
MSHA0070	Amendment to Provider-Contract State Law Coordinating Provisions	ChoiceCare	Smyth County Community Hospital
MSHA0071	Agreement for Medical Services	Christian Care Centers of Johnson City, Inc.	Mountain States Health Alliance
MSHA0072	Participating Provider Agreement – Virginia	CIGNA Behavioral Health, Inc.	Dionis K. Anderson
MSHA0073	Institutional Services Agreement	CIGNA Behavioral Health, Inc.	Mountain States Health Alliance

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0074	CIGNA HealthCare Ambulatory Center, Exhibit A, Fee Schedule and Reimbursement Terms	CIGNA HealthCare of Tennessee, Inc.	Kingsport Ambulatory Surgery Center
MSHA0075	Attachment to Exhibit A (directly above) (regarding max allowable reimbursement)	CIGNA HealthCare of Tennessee, Inc.	Kingsport Ambulatory Surgery Center
MSHA0076	Provider Group Services Agreement	CIGNA HealthCare of Tennessee, Inc.	Blue Ridge Medical Management
MSHA0077	Hospital Services Agreement	Cigna HealthCare of Tennessee, Inc.	Mountain States Health Alliance
MSHA0078	Medical Services/Hospital Participation Contract	Commonwealth of Virginia Department of Health, Office of Family Health Services	Smyth County Community Hospital
MSHA0079	Hospitalization Services Agreement	Commonwealth of Virginia Department of Rehabilitative Services	Smyth County Community Hospital
MSHA0080	Contract Renewal	Commonwealth of Virginia, Department of Mental Health, Mental Retardation and Substance Abuse Services	Smyth County Community Hospital
MSHA0081	Letter Agreement	Commonwealth of Virginia, Virginia Department of Health, Cumberland Plateau Health District	Russell County Medical Center
MSHA0082	Standard Contract	Commonwealth of Virginia, Virginia Department of Health, Cumberland Plateau Health District	Russell County Medical Center

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0083	CMVI Hospital	Comp Management of Virginia, Inc.	Norton Community Hospital
MSHA0084	Facility Participation Agreement (plus Amendment)	Corphealth, Inc. d/b/a LifeSynch	Mountain States Health Alliance (Johnson City Medical; Woodridge Psychiatric; Russell County Medical; Mountain States Health Alliance Outpatient Behavioral Health/Indian Path Medical; Sycamore Shoals)
MSHA0085	Attachment A PHO Reimbursement	Corvel Corporation	Southwest Virginia Healthnet - JMH
MSHA0086	Hospital Agreement	Corvel Corporation	Russell County Medical Center
MSHA0087	Corvel Preferred Provider Organization Facility Agreement	Corvel Healthcare Corporation	Mountain States Health Alliance
MSHA0088	Corvel Preferred Provider Organization Facility Agreement	Corvel Healthcare Corporation	Kingsport Ambulatory Surgery Center, LLC dba Kingsport Day Surgery
MSHA0089	Physician Agreement	Corvel Healthcare Corporation	Blue Ridge Medical Management Corporation
MSHA0090	Psychiatric Service Agreement for Inpatient Purchase of Service	Cumberland Mountain Community Services, Dickenson County Behavioral Health Services, Highlands Community Services, Mount Rogers Community Services, New River Valley Community Services, Planning District 1 Behavioral Health Services	Russell County Medical Center
MSHA0091	Standard Contract	Cumberland Plateau Health District	Russell County Medical Center

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0092	Behavioral Health Services Agreement	Dickenson County Behavioral Health Services	Russell County Medical Center
MSHA0093	Agreement Between Mountain States Health Alliance and The Division of Rehabilitation Services of The Tennessee Department of Human Services	Division of Rehabilitation Services of the Tennessee Department of Human Services	Mountain States Health Alliance
MSHA0094	Memoranda of Understanding and Service Agreement	EvaluMed	Not specified; mentions “Mountain States Health Alliance physical therapist” and “Managed Care”
MSHA0095	Amendment to Hospital Agreement	First Health Group Corp.	Mountain States health Alliance
MSHA0096	The First Health Network Hospital Contract	First Health Group Corp.	Norton Community Hospital
MSHA0097	Participating Hospital Agreement	Fortified Provider Network	Johnston Memorial Hospital
MSHA0098	Psychiatric Bed Day Purchase Agreement	Frontier Health, Inc./PD 1	Russell County Medical Center
MSHA0099	Galaxy Health Network Facility Agreement	Galaxy Health Network	Russell County Medical Center
MSHA0100	Letter of Agreement	Galaxy Health Network	Unicoi County Memorial Hospital
MSHA0101	Galaxy Health Network Facility Agreement	Galaxy Health Network	Russell County Medical Center
MSHA0102	Gateway Health Delegated Credentialing Agreement	Gateway Health	Blue Ridge Medical Management
MSHA0103	Gateway Health Alliance, Inc.	Gateway Health Alliance, Inc.	Dickenson Community Hospital, Norton Community Hospital, Smyth County Community Hospital, Mountain States Health Alliance d/b/a Russell County Medical Center
MSHA0104	Physician Hospital Organization Participation Agreement	Gateway Health Alliance, Inc.	Southwest Virginia Health Network - JMH PHO(includes rates for both physicians and facility)
MSHA0105	Network Participation Agreement	Gateway Health Alliance, Inc.	Dickenson Community Hospital, Norton Community Hospital, Smyth County

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
			Community Hospital, and Mountain States Health Alliance, d/b/a Russell County Medical Center
MSHA0106	Hospital Participation Agreement	Gateway Health Alliance, Inc.	Russell County Medical Center
MSHA0107	Therapy Management Program Provider Agreement	GENEX Services, dba Network Synergy Group	Mountain States Health Alliance
MSHA0108	Agreement for outpatient services	Grayson Nursing & Rehabilitation Center- Skilled Nursing Facility	Smyth County Community Hospital, Inc.
MSHA0109	Preferred Hospital Agreement	Health Payors Organization, LTD.	Johnson City Medical Center Hospital, Inc.
MSHA0110	Physician Hospital Organization Participation Agreement	Health Value Management dba ChoiceCare Network	Southwest Virginia Health Network
MSHA0111	Hospital Participation Agreement	Health Value Management, Inc. d/b/a ChoiceCare Network	Mountain States Health Alliance
MSHA0112	Amendment One to Hospital Participation Agreement	Health Value Management, Inc. d/b/a ChoiceCare Network	Mountain States Health Alliance
MSHA0113	Physician Hospital Organization Participation Agreement	Health Value Management, Inc. d/b/a ChoiceCare Network	Southwest Virginia Health Network
MSHA0114	Letter of Intent for Participation in HealthKeepers, Inc.'s Network Serving the Virginia Financial Alignment Demonstration for Dual Eligible	Healthkeepers, Inc.	Johnston Memorial Hospital, Dickenson Community Hospital, Norton Community Hospital, Smyth County Community Hospital, Kingsport Day Surgery Center, LLC, Mediserve Medical Equipment of Kingsport-Abingdon, Mountain States Health Alliance, d/b/a, Russell County Medical Center, Mountain States health Alliance d/b/a. Indian Path Medical Center
MSHA0115	Amendment 1 to the Home Health Care Provider Agreement	HealthKeepers, Inc.	Mountain States Health Alliance

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0116	Anthem HealthKeepers Provider Agreement	HealthKeepers, Inc.	Not identified, this packet is not executed
MSHA0117	Medicare Medicaid Dual Integration Participation Attachment to the HealthKeepers, Inc. Skilled Nursing Facility Provider Agreement	HealthKeepers, Inc.	Not identified, this agreement is not executed
MSHA0118	Medical Equipment Supplier	Healthkeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc.	Community Home Care
MSHA0119	Amendment 1 to the Home Health Care Provider Agreement	Healthkeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc.	Smyth County Regional Homecare
MSHA0120	Amendment 1 to the Home Health Care Provider Agreement	Healthkeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc.	Smyth County Regional Homecare
MSHA0121	HMO Home Health Agency Agreement	Healthkeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc.	Smyth County Community Home Care
MSHA0122	Psychiatric Bed Day Purchase Agreement	Highlands Community Services	Russell County Medical Center
MSHA0123	First Amendment to Agreement - added Unicoi - WC	Holston Distributing Inc.	Mountain States Health Alliance
MSHA0124	Ancillary Agreement - WC	Holston Distributing Inc.	Mountain States Health Alliance
MSHA0125	Horizon Health EAP Services, Inc. Facility Agreement	Horizon Health EAP Services, Inc.	Mountain States Health Alliance dba Sycamore Shoals Hospital
MSHA0126	Horizon Health EAP Services, Inc. Facility Agreement	Horizon Health EAP Services, Inc.	Mountain States Health Alliance dba Johnson City Medical Center (dba Woodridge Psychiatric Hospital)

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0127	Group Provider Agreement	Horizon Health EAP Services, Inc.	Blue Ridge Psychiatry/Woodbridge Hospital Physicians
MSHA0128	Hospice of Southwest Virginia Contract for Hospice Inpatient Acute Care	Hospice of Southwest Virginia	Smyth County Community Hospital
MSHA0129	Hospice of Southwest Virginia Contract for Hospice Inpatient Acute Care	Hospice of Southwest Virginia	Smyth County Community Hospital
MSHA0130	Attachment E-3 Medicare Advantage HMO, POS and PPO Reimbursement	Humana (see Amendment One to Mountain States Health Alliance and Humana Hospital Participation Agreement)	Mountain States Health Alliance
MSHA0131	Amendment to Agreement	Humana Government Business, Inc. d/b/a Humana Military	Mountain States Health Alliance (Unicoi Locations)
MSHA0132	Hospital Participation Agreement	Humana Health Plan, Inc.	Mountain States Health Alliance
MSHA0133	Amendment One to Hospital Participation Agreement	Humana Health Plan, Inc.	Mountain States Health Alliance
MSHA0134	Amendment Two to Hospital Participation Agreement	Humana Health Plan, Inc.	Mountain States Health Alliance
MSHA0135	Physician Participation Agreement	Humana Insurance Company, Humana Health Plan, Inc.	Blue Ridge Medical Management
MSHA0136	HMHS Amendment to Hospital Agreement	Humana Military Health Services, Inc.	Mountain States Health Alliance
MSHA0137	Letter Of Agreement (under USP Lee County)	Integrated Medical Solutions, LLC	Mountain States Health Alliance (IPMC & NCH)
MSHA0138	Eight Amendment to Integrated Solutions Health Network Network Participation Agreement	Integrated Solutions Health Network, LLC, Anew Care Collaborative, LLC, Crestpoint Health Insurance Company	Mountain States Pharmacy at State of Franklin, Mountain States Pharmacy at JCMC, Mountain States Pharmacy at Kingsport, Mountain States Pharmacy at Norton, Mountain States Pharmacy at JMH

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0139	Letter of Agreement (plus Amendment dated July 1, 2014)	INTotal Health, LLC (formerly known as Amerigroup Virginia, Inc.)	ISHN, LLC - Physicians
MSHA0140	6th Amendment to ISHN Network participation Agreement	ISHN - AnewCare/CrestPoint	Contract between ISHN and its subsidiaries - Professionals
MSHA0141	Sixth Amendment to ISHN Network Participation Agreement (amending March 27, 2012 Agreement)	ISHN Entities (not signed)	Mountain States Health Alliance (Kingsport Day Surgery Center, Dickenson Community Hospital, Franklin Woods, Indian Path, Johnson City Medical, Woodridge Hospital, Johnson County Community Hospital, Johnston Memorial Hospital, Norton Community Hospital, Russell County Medical Center, Smyth County Community Hospital, Sycamore Shoals, Quillen Rehabilitation, Niswonger Children's Hospital)
MSHA0142	Amendment Seven to ISHN Network Participation Agreement (Amerigroup TennCare Amendment)	ISHN, Anew Care Collaborative, LLC and Crestpoint Health Insurance Company	Blue Ridge Medical Management Incorporated
MSHA0143	Tenth Amendment to Integrated Solutions Health Network Participation Agreement (Amerigroup TennCare Amendment)	ISHN, LLC, Anew Care Collaborative, LLC and Crestpoint Health Insurance Company	Mountain States Health Alliance (Franklin Woods, Indian Path Medical, Johnson City Medical, Woodridge Hospital, Johnson County Community Hospital, Sycamore Shoals, Unicoi County Memorial Hospital, Niswonger Children's Hospital, Kingsport Day Surgery Center, East Tennessee ASC, Johnston Memorial Hospital

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0144	Network Participation Agreement	ISHN, LLC (and related entities)	Mountain States (all Mountain States Health Alliance locations)
MSHA0145	Amendment to Network Participation Agreement (MA Amendment)	ISHN, LLC (and related entities)	Mountain States (BRMMC, APP, NCPS)
MSHA0146	Seventh Amendment to Network Participation Agreement (MA Amendment)	ISHN, LLC (and related entities)	Mountain States Health Alliance (Johnson City Medical/Woodridge, Quillen Rehab, Johnson County Community Hospital, Johnson County Home Health, Johnson County Family Medicine, Princeton Transitional Care, Franklin Woods, Sycamore Shoals (Hospital and Psych Unit), Medical Center HomeCare Services of Kingsport, Kingsport Day Surgery, Russell County (Medical Center, Psychiatric Unit, Swing Bed, Home Health, Hospice), Mountain States Medical Group Riverside Family Clinic, Smyth County (Community Hospital, Regional Home Care, Frances Marion Manor, Rehab Unit, Glade Springs Family Medicine), Norton Community Hospital, (including Skilled Nursing, Rehab, Home Care, Home Health), Dickenson Community Hospital, Johnston Memorial Hospital, Johnston Memorial Home Care, Mediserve medical Equipment of Kingsport – Greeneville, Morristown, Knoxville, Gray, Abingdon; Wilson Pharmacy, Inc.
MSHA0147	Agreement for Medical Services	Ivy Hall Nursing Home, Inc.	Mountain States Health Alliance
MSHA0148	Preferred Provider Acceptance Agreement	Johnston & Associates, Inc.	Mountain States Health Alliance - WC TN & VA Diagnostic

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0149	Preferred Provider Acceptance Agreement	Johnston & Associates, Inc.	Mountain States Health Alliance - TN WC Rehab
MSHA0150	Preferred Provider Acceptance Agreement	Johnston & Associates, Inc.	Mountain States Health Alliance VA WC Rehab
MSHA0151	Business Associate Addendum	KDM, Inc. dba Durham-Hensley Health and Rehabilitation	Mountain States Health Alliance
MSHA0152	Agreement for Medical Services	KDM, Inc. dba Durham-Hensley Health and Rehabilitation	Mountain States Health Alliance
MSHA0153	Agreement for Medical Services	Lakebridge Medical Investors, LLC dba Lakebridge Health Care Center	Mountain States Health Alliance
MSHA0154	M.D. Individual Practice Association, Inc. Hospital Service Agreement	M.D. Individual Practice Association, Inc.	Russell County Medical Center, Inc.
MSHA0155	Medicaid Addendum to Magellan Behavioral Health, Inc. Provider Agreement	Magellan Behavioral Health, Inc.	Blue Ridge Medical Management Corporation
MSHA0156	Facility and Program Participation Agreement	Magellan Behavioral Health, Inc.	Mountain States Health Alliance
MSHA0157	Amendment(s) to Magellan Behavioral Health, Inc. Provider Agreement.	Magellan Behavioral Health, Inc.	Mountain States Health Alliance
MSHA0158	Facility and Program Participation Agreement	Magellan Behavioral Health, Inc.	Mountain States Health Alliance
MSHA0159	Participating Provider Agreement	Managed Health Network, Inc.	Russell County Medical Center, Inc.
MSHA0160	Amendment to Participating Provider Agreement	Managed Health Network, Inc.	Russell County Medical Center, Inc.
MSHA0161	Medcost Participating Physician Organization Agreement	MedCost, Inc.	Southwest Virginia Healthnet

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0162	MedCost Participating Physician Organization Agreement	MedCost, LLC	Southwest Virginia Healthnet
MSHA0163	Amendment No. 1 Medcost, Inc. Hospital Agreement	Medcost,Inc.	Johnston Memorial Hospital
MSHA0164	Amendment to Hospital Service Agreement	Medical Control Network Solutions, Inc.	Norton Community Hospital
MSHA0165	Facility Service Agreement	Medical Control Network Solutions, Inc.	Norton Community Hospital
MSHA0166	Medical Network Hospital Network Provider Agreement	Medical Network, Inc.	Sycamore Shoals
MSHA0167	Facility Network Participation Agreement	Mental Health Associates, Inc.	ISHN, LLC
MSHA0168	Facility Participation Agreement	Modern Chevrolet	Russell County Medical Center
MSHA0169	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Community Physicians Services Corporation
MSHA0170	Mountain Empire PACE Provider Agreement, as amended	Mountain Empire Older Citizens, Inc.	Norton Community Hospital Home Health
MSHA0171	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Norton Community Physicians Services
MSHA0172	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Norton Community Hospital
MSHA0173	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Community Physicians Services Corporation
MSHA0174	Mountain Empire PACE Provider Agreement	Mountain Empire Older Citizens, Inc.	Community Home Care, Norton Community Hospital
MSHA0175	Multiplan, Inc. Participating Practitioner Agreement	MultiPlan, Inc.	No group contract just individual contracts so multiple contracts with multiple effective dates.

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0176	Letter of Agreement MVP Health Care Services Agreement for Medicare PPO	MVP Health Plan, Inc., MVP Select Care, Inc. and MVP Affiliates	Mountain States Health Alliance and Blue Ridge Medical Management
MSHA0177	Participating Agreement for an Integrated Delivery System or Physician Hospital Organization	National Preferred Provider Network, Inc.	Southwest Virginia Health Network (JMH & Physicians)
MSHA0178	Health Care Facility Agreement	Novanet, Inc.	MSHA Hospitals
MSHA0179	HealthCare Professional Agreement (as amended)	Novanet, Inc.	BRMMC
MSHA0180	Health Care Facility Agreement	Novanet, Inc.	KDS
MSHA0181	Health Care Professional Agreement	Novanet, Inc.	BRMMC, Norton Community Physician Services, Abingdon Physician Partners, Dickenson Medical Associates, Dickenson Community Hospital ER Physicians, Smyth County Community Hospital ER Physicians, Smyth County Community Hospital Physicians, Russell County Medical Center ER Physicians, Russell County Medical Center Physicians, Johnston Memorial Hospital Physicians
MSHA0182	Health Care Professional Agreement	Novanet, Inc.	Blue Ridge Medical Management Corporation
MSHA0183	Health Care Facility Agreement Worker's Compensation Benefit Programs	Novanet, Inc.	Kingsport Day Surgery
MSHA0184	Health Care Facility Agreement Worker's Compensation Benefit Programs	Novanet, Inc.	Mountain States Health Alliance
MSHA0185	Optimum Choice, Inc. Hospital Service Agreement	Optimum Choice, Inc.	Russell County Medical Center, Inc.

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0186	Participating Agreement with 4Most Health Network	Physician Services, LC	Southwest Virginia Health Network (Facility & Physician)
MSHA0187	Facility Participation Agreement	Pittston Coal	Russell County Medical Center
MSHA0188	USA Care Plan	Preferred Care	Facility not listed in agreement
MSHA0189	Professional Service Agreement	Premier Comp Solutions, LLC	Mountain States Health Alliance
MSHA0190	Professional Service Agreement	Premier Comp Solutions, LLC	Mountain States Health Alliance
MSHA0191	Letter of Agreement	Prime Health Services, Inc.	Blue Ridge Medical Management Corporation
MSHA0192	PHCS Participating Professional Agreement	Private Healthcare Systems, Inc.	no group contract just multiple individual contracts with multiple effective dates.
MSHA0193	PHCS Participating Facility Agreement	Private Healthcare Systems, Inc.	Mountain States Health Alliance d/b/a Johnson City Medical Center
MSHA0194	Preferred Facility Agreement	Private Healthcare Systems, Inc.	Norton Community Hospital
MSHA0195	Facility Agreement (2nd, 3rd, 4th, 6-8th Amendments)	Private Healthcare Systems, Inc.	Mountain States Health Alliance
MSHA0196	Letter of Understanding	Public Risk Services, Inc. /The Pool	Mountain States Health Alliance
MSHA0197	TennCare Addendum – Bureau of TennCare required Language – Provider Agreements	River Valley plan	TennCare - Deemed policy for MSHA entities including Physicians
MSHA0198	Agreement for Medical Services	Roan Highlands Medical Investors, LLC dba Roan Highlands Nursing Center	Mountain States Health Alliance
MSHA0199	Hospital Agreement	Russell County Detention Center	Russell County Medical Center
MSHA0200	Network Access Agreement	Sentara Health Plans, Inc.	ISHN, LLC (MSHA & MSMG)

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0201	3rd Amendment to Network Access Agreement (Cova Commercial)	Sentara Health Plans, Inc.	ISHN, LLC - (MSHA & MMG)
MSHA0202	Letter of intent to participate in the USP LEE provider network	Seven Corners, Inc.	Mountain States Health Alliance
MSHA0203	Medical Equipment Supplier Medicare Advantage Agreement	Southeast Services, Inc.	Community Home Care
MSHA0204	Home Health Care Medicare Advantage Agreement	Southeast Services, Inc.	Smyth County Community Hospital
MSHA0205	Amendment 1 to the Home Health Care Provider Agreement	Southeast Services, Inc.	Smyth County Homecare
MSHA0206	Home Health Care Medicare Advantage Agreement	Southeast Services, Inc.	Norton Community Home Health
MSHA0207	Amendment 1 to the Home Health Care Provider Agreement	Southeast Services, Inc.	Mountain States Health Alliance
MSHA0208	Anthem Blue Cross and Blue Shield's Provider Agreement -SNF	Southeast Services, Inc.	Not identified, this packet is not executed
MSHA0209	Anthem Blue Cross and Blue Shield's Provider Agreement - SNF	Southeast Services, Inc.	Not identified, this packet is not executed
MSHA0210	Southern Health Services, Inc. PHO Agreement / Coventry - VA Medicaid	Southern Health Services, Inc.	ISHN, LLC (MSHA & MSMG)
MSHA0211	Contract	Southwest Virginia Mental Health Institute	Smyth County Community Hospital
MSHA0212	Hospital To Hospital Transfer Agreement	Southwest Virginia Mental Health Institute	Smyth County Community Hospital

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0213	Tennessee Department of Health, Communicable & Environmental Diseases and Emergency Preparedness, HIV/STD Programs , Ryan White Part B Program	State Of Tennessee Department of Health	Unicoi County Memorial Hospital
MSHA0214	Mammography Screening Program	Tennessee Department of Health	Mountain States Health Alliance
MSHA0215	Letter of Agreement	Tennessee Department of Health	Unicoi County Memorial Hospital
MSHA0216	CEDEP Program (Ryan White)	Tennessee Department of Health	Johnson City Medical Center - Facilities to be determined based on vendor forms
MSHA0217	Contract	The Infant Toddler Connection of Mount Rogers	Smyth County Community Hospital
MSHA0218	Amendment No. 1 to The Initial Group Provider Participation Agreement	The Initial Group	Southwest Virginia Health Network - APP
MSHA0219	Managed Care Agreement	The Initial Group, Inc.	ISHN, LLC
MSHA0220	Three Rivers Provider Network Agreement	Three Rivers Provider Network	Southwest Health Network (Hospital Affiliation – Johnston Memorial Hospital)
MSHA0221	Provider Network Agreement	Three Rivers Provider Network, Inc.	Southwest Virginia Health Network - JMH physicians
MSHA0222	Amendment to the Trigon Services, Inc. Home Health Care Agreement	Trigon Services, Inc.	Smyth County Community
MSHA0223	Home Health Care Agreement	Trigon Services, Inc.	Smyth County Community Hospital Home Health
MSHA0224	Amendment to the Trigon Services, Inc. Home Health Care Agreement	Trigon Services, Inc.	Smyth County Community
MSHA0225	Institution Agreement (as amended by VA PCCC Amendment)	TriWest Healthcare Alliance Corp.	Mountain States Health Alliance

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0226	Cooperating Provider Agreement	Trustees of the UMWA 1992 (and 1993) Benefit Plan;	Mountain States Health Alliance d/b/a Russell County Medical Center Home Health
MSHA0227	Cooperating Provider Agreement	Trustees of the United Mine Workers of America Combined Benefit Fund, the Trustees of UMWA 1992 Benefit Plan , the Trustees of the UMWA 1993 Benefit Plan and the Trustees of the UMWA Prefunded Benefit Plan	Mountain States Health Alliance dba Russell County Medical Center
MSHA0228	Agreement	Trustees of the UMWA 1992 (and 1993) Benefit Plan;	Norton Community Hospital
MSHA0229	Agreement	UMWA Health and Retirement	Mountain States Managed Care, Inc. (TN Facilities)
MSHA0230	Assignment and Assumption Agreement	Unicoi Memorial Hospital	Mountain States Health Alliance
MSHA0231	United Behavioral Health, Inc. Facility Participation Agreement	United Behavioral Health, Inc.	Mountain States Health Alliance d/b/a Indian Path Pavilion
MSHA0232	Fifth Amendment to United Behavioral Health, Inc. Facility Participation Agreement	United Behavioral Health, Inc.	Mountain States Health Alliance d/b/a Indian Path Pavilion
MSHA0233	1st Amendment to the United Behavioral Health Tenncare Program Facility Participation Agreement	United Behavioral Health, Inc.	Mountain States Health Alliance d/b/a Sycamore Shoals Hospital and Woodbridge Psychiatric Hospital
MSHA0234	Ambulatory Surgical Center All Payer Appendix	United Healthcare	East Tennessee Ambulatory Surgery Center

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0235	Ambulatory Surgical Center Compass Payer Appendix - Exchange	United Healthcare	East Tennessee Ambulatory Surgery Center
MSHA0236	Ambulatory Surgical Center All Payer Appendix	United Healthcare	Kingsport Ambulatory Surgery Center
MSHA0237	Ambulatory Surgical Center Compass Payer Appendix - Exchange	United Healthcare	Kingsport Ambulatory Surgery Center
MSHA0238	Durable Medical Equipment Services All Payer Appendix	United Healthcare	Mediserve Medical Equipment of Kingsport, Inc., Mountain States Pharmacy and Community Home Care
MSHA0239	All Payer Appendix	United Healthcare	Mountain States Health Alliance dba MCHC, MCHC of Kingsport, Johnson County Home Health and Norton Home Health, Johnston Memorial Home Health, Unicoi County Home Health , Russell County Home Health and Smyth County Regional Home Care
MSHA0240	All Payer Appendix	United Healthcare	Mountain States Health Alliance dba Medical Center Hospice and Russell County Hospice
MSHA0241	Home Infusion Therapy Services All Payer Appendix	United Healthcare	Mountain States Pharmacy
MSHA0242	Ambulatory Surgical Center Medicare SNP Payer Appendix	United Healthcare	Kingsport Ambulatory Surgery Center

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0243	Medicare SNP Home Health Services Payment Appendix	United Healthcare	Norton Community Home Care, Mediserve Medical Equipment of Kingsport, Mountain States Health Alliance dba Medical Center Home Health, Mountain States Health Alliance dba Johnson County Home Health, Mountain States Health Alliance dba Medical Center HomeCare Services of Kingsport, Smyth County Regional HomeCare, Norton Community Hospital Home Health, Johnston Memorial Home Health, Russell County Home Health
MSHA0244	Ambulatory Surgical Center Medicaid Payer Appendix	United Healthcare	Kingsport Ambulatory Surgery Center
MSHA0245	Home Health Services Medicaid Payer Appendix	United Healthcare	Norton Community Home Care, Mediserve Medical Equipment of Kingsport, Mountain States Health Alliance dba Medical Center Home Health, Mountain States Health Alliance dba Johnson County Home Health, Mountain States Health Alliance dba Medical Center HomeCare Services of Kingsport, Smyth County Regional HomeCare, Norton Community Hospital Home Health, Johnston Memorial Home Health, Russell County Home Health
MSHA0246	Medicaid Hospice Payer Appendix	United Healthcare	Medical Center Hospice, Hospice Johnson City Medical Center, Russell County Hospice
MSHA0247	Amendment to Facility Participation Agreement	United Healthcare of Tennessee, Inc.	East Tennessee Ambulatory Surgery Center
MSHA0248	Amendment to Facility Participation Agreement	United Healthcare of Tennessee, Inc.	Kingsport Ambulatory Surgery Center

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0249	Eleventh Amendment to Facility Participation Agreement	United Healthcare of Tennessee, Inc.	Wilson Pharmacy, Inc.
MSHA0250	Amendment to Facility Participation Agreement	United Healthcare of Tennessee, Inc.	Kingsport Ambulatory Surgery Center
MSHA0251	Network Hospital Provider Agreement (August 22, 2000) -- Amendment to Agreement	United Healthcare Plan of the River Valley, Inc.	Mountain States Health Alliance
MSHA0252	Network Hospital Provider Agreement (November 1, 2004) -- Amendment to Agreement	United Healthcare Plan of the River Valley, Inc.	Dickinson Community Hospital
MSHA0253	Network Hospital Provider Agreement (August 22, 2000) -- Amendment to Agreement	United Healthcare Plan of the River Valley, Inc.	Mountain States Health Alliance
MSHA0254	Network Hospital Provider Agreement (January 1, 2001) -- Amendment to Agreement	United Healthcare Plan of the River Valley, Inc.	Norton Community Hospital
MSHA0255	Agreement	United Mine Workers of American, Combined Benefit Fund, UMWA 1992 Benefit Plan, UMWA 1993 Benefit Plan	Blue Ridge Medical Management Corporation
MSHA0256	Letter of Agreement	United Payors and United Providers, Inc.	Columbia Healthcare Network of Tri-Cities, Inc.
MSHA0257	Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Abingdon Physician Partners
MSHA0258	Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Blue Ridge Medical Management

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0259	Third Amendment to Facility Participation Agreement	UnitedHealthcare Insurance Company	Mountain States Health Alliance – Russell County Medical Center
MSHA0260	Twelfth Amendment to Facility Participation Agreement	UnitedHealthcare Insurance Company	Russell County Medical Center
MSHA0261	Facility Participation Agreement (plus Amendments dated April 1, 2012; August 15, 2013; July 1, 2015)	UnitedHealthcare Insurance Company	Mountain States Health Alliance (Johnson City Medical, Indian Path Medical, Indian Patch Medical Skilled Nursing, Medical Center Home Health, Medical Center Hospice, Quillen Rehab, Johnson City Specialty, Johnson County Community Hospital, Johnson County Home Health, Johnson County Medical Group, Northside, Franklin Woods Community, Princeton Transitional Care, Sycamore Shoals, Medical Center HomeCare Services of Kingsport, Russell County Medical Center (Riverside, Home Care, Hospice), Kingsport Day Surgery, Smyth County Community Hospital (Regional HomeCare, Frances Marion Manor, Glade Springs Clinic), Norton Community Hospital (Skilled Nursing, Rehab, Home Care, Home Health), Dickenson Community Hospital, Johnston Memorial Hospital, Johnston Memorial Home Health, Mediserve Medical Equipment of Kingsport)
MSHA0262	Amendment Number 2 to Medical Group Participation Agreement	UnitedHealthcare Insurance Company	Abingdon Physician Partners
MSHA0263	Second Amendment to Facility Participation Agreement	UnitedHealthcare Insurance Company	Wilson's Pharmacy

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0264	Amendment Number 2 to Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Abingdon Physician Partners
MSHA0265	Amendment Number 2 to Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Blue Ridge Medical Management
MSHA0266	Amendment Number 12 to Medical Group Participation Agreement	UnitedHealthCare Insurance Company	Blue Ridge Medical Management
MSHA0267	12th Amendment to Facility Participation Agreement (original Agreement dated December 1, 2007)	UnitedHealthcare Insurance Company, Inc.	Russell County Medical Center
MSHA0268	Amendment to Facility Participation Agreement (original Agreement dated February 1, 2012)	UnitedHealthcare of Tennessee, Inc.	Unicoi County Memorial Hospital
MSHA0269	Amendment to Facility Participation Agreement (original Agreement dated February 1, 2012)	UnitedHealthcare of Tennessee, Inc.	Unicoi Memorial Hospital
MSHA0270	Hospital Provider Agreement - Community Plan	UnitedHealthcare Plan of River Valley, Inc.	Mountain States Health Alliance
MSHA0271	Tennessee Program Network Practitioner Group Provider Agreement - Community Plan	UnitedHealthcare Plan of the River Valley, Inc.	Blue Ridge Medical Management Corporation
MSHA0272	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Dickenson Community Hospital
MSHA0273	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Mountain States Health Alliance (on behalf of: Johnson City Medical; Indian Path Medical; Franklin Woods; Johnson County Community; North Side; Quillen Rehabilitation; Sycamore Shoals; Smyth County; Medical Center Hospice; Kingsport

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
			Ambulatory Surgery; Medical Center Home Care; Hospice Care of Johnson City; Mediserve Medical Equipment of Kingsport; Johnson County Home Health; Johnston Memorial Hospital
MSHA0274	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Mountain States Health Alliance
MSHA0275	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Mountain States Health Alliance
MSHA0276	Network Hospital Provider Agreement – Amendment	UnitedHealthcare Plan of the River Valley, Inc.	Norton Community Hospital
MSHA0277	Home Health Ancillary Provider Services Agreement	Univita Healthcare Solutions LLC	Mountain States Health Alliance
MSHA0278	Health Care Service Provider Agreement	USA Health Network Company, Inc.	Southwest Virginia Healthnet (Base JMH)
MSHA0279	Health Care Service Provider Agreement	USA Health Network Company, Inc.	Southwest Virginia Healthnet (JMH Physicians)
MSHA0280	Health Care Service Facility Agreement	USA Managed Care Organization, Inc.	Norton Community Hospital
MSHA0281	Health Care Service Facility Agreement	USA Managed Care Organization, Inc.	Smyth County Community Hospital
MSHA0282	Health Care Service Facility Agreement (as amended)	USA Managed Care Organization, Inc.	Mountain States Health Alliance
MSHA0283	Facility Agreement (as amended)	Value Options, Inc.	Mountain States Health Alliance dba Indian Path Pavilion, Indian Path Medical Center and Sycamore Shoals Hospital

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0284	Addendum to Provider Agreement	Value Options, Inc.	Mountain States Health Alliance dba Woodbridge Psychiatric Hospital and Sycamore Shoals
MSHA0285	Amendment to Facility Agreement	Value Options, Inc.	Woodbridge Psychiatric Hospital
MSHA0286	Facility Agreement Amendment	Value Options, Inc.	Mountain States Health Alliance
MSHA0287	Facility/Program Agreement	Value Options, Inc.	Mountain States Health Alliance dba Woodridge Psychiatric Hospital
MSHA0288	Addendum to Provider Agreement	Value Options, Inc.	Mountain States Health Alliance dba Woodbridge Psychiatric Hospital
MSHA0289	Standard Contract	Virginia Department of Health	Johnston Memorial Hospital, Inc.
MSHA0290	Standard Contract	Virginia Department of Health	Smyth County Community Hospital
MSHA0291	Virginia Department of Health Office of Purchasing and General Services Standard Contract	Virginia Department of Health, Mount Rogers health district	Johnston Memorial Hospital, Inc.
MSHA0292	Standard Contract	Virginia Department of Health, Mount Rogers Health District	Johnston Memorial Hospital, Inc.
MSHA0293	Virginia Health Network, Inc. Physician – Hospital Organization	Virginia Health Network, Inc.	Southwest Virginia Health Network (JMH & Physicians)
MSHA0294	Hospital Agreement (as amended by those certain Amendments to the June 1, 2001 Agreement Russell County Medical Center and Virginia Health Network, Inc.)	Virginia Health Network, Inc.	Russell County Medical Center
MSHA0295	Physician – Hospital Organization (as amended)	Virginia Health Network, Inc.	Southwest VA. Health Network

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0296	Amendment to the May 1, 1999 Agreement between Mountain States Health Alliance and Virginia Health Network, Inc.	Virginia Health Network, Inc.	Smyth County Community Hospital
MSHA0297	Administrative Contract (plus 1st Amendment dated 7/1/12)	Virginia Premier Health Plan, Inc.	ISHN, LLC - Base Agreement (Facilities & Physicians)
MSHA0298	1st Amendment - Group	Virginia Premier Health Plan, Inc.	ISHN, LLC
MSHA0299	Volunteer State Health Plan, Inc. Home and Community Based Services Agreement for Non-Healthcare Providers	Volunteer State Health Plan, Inc.	Home and Community Based Services Non-Healthcare Provider/MSHS dba Mountain States Lifeline
MSHA0300	Amendment to Blue Care/TennCare Select - Primary	Volunteer State Health Plan, Inc.	Blue Ridge Medical Management Corporation
MSHA0301	Attachment BLUECARE Group Practice Specialist/Amendment to TennCare Select	Volunteer State Health Plan, Inc.	Blue Ridge Medical Management
MSHA0302	Amendment to the Bluecare Group Practice Specialist Attachment	Volunteer State Health Plan, Inc.	Blue Ridge Medical Management
MSHA0303	BlueCare Tennessee Professional Agreement	Volunteer State Health Plan, Inc. dba BlueCare Tennessee	Blue Ridge Medical Management Corporation
MSHA0304	Letter of Agreement – Hospital	Windsor Health Plan, Inc.	Unicoi County Memorial Hospital, Inc. & Nursing Home
MSHA0305	Amendment to PHO by and between Beechstreet Corp.	Beech Street Corporation	Southwest Virginia Network (APP)
MSHA0306	Amendment 1	The Initial Group	Southwest Virginia Network (APP)
MSHA0307	Amendment to the Existing Agreement	USA Managed Care Organization, Inc.	Southwest Virginia Network (APP)
MSHA0308	SelectNet Plus, Inc. Hospital Participation Agreement	SelectNet Plus, Inc. (Accorida National)	Russell County Hospital

Reference No.	Agreement Title	Payor	Mountain States Health Alliance Contracting Party
MSHA0309	National Capital Preferred Provider Organization Participation Agreement	National Preferred Provider Organization (Unicare)	Russell County Medical Center
MSHA0310	Letter of Agreement; Centurion of Tennessee	Centurion	Mountain States Health Alliance
MSHA0311	Contractor for Specimen Collection Agreement	Laboratory Corporation of America Holdings	Johnston Memorial Hospital, Inc.
MSHA0312	Amendment (to Hospital Services Agreement)	Aetna Health Inc.	Mountain States Health Alliance (updating Home Health to reflect inpatient hospice rate).
MSHA0313	Twelfth Amendment to ISHN Network Participation Agreement (amending March 27, 2012 Agreement)	ISHN Entities	Mountain States Health Alliance (adding Inpatient Hospice to Home Health for commercial plan)
MSHA0314	Eighteenth Amendment to ISHN Network Participation Agreement (amending March 27, 2012 Agreement)	ISHN Entities	Mountain States Health Alliance (adding Unicoi Hospital)
MSHA0315	Thirteenth Amendment to ISHN Network Participation Agreement (amending March 27, 2012 Agreement)	ISHN Entities	Mountain States Health Alliance (adding Unicoi Hospital to Optima and annual rate increase)
MSHA0316	MSHA Rate Escalator Effective 1/1/2016 Attachment A	Humana ChoicesCommercial	Kingsport Ambulatory Surgery Center, L.L.C.
MSHA0317	MSHA Rate Escalator Effective 1/1/2016 Attachment A	Humana Choices Commercial	MSHA Hospitals
MSHA0318	MA CAH Rate Structure	Humana Medicare	Dickenson Community Hospital, Inc.
MSHA0319	MSHA Rate Escalator Effective 1/1/2016 Attachment E-1 & E2	Humana Commercial	Kingsport Ambulatory Surgery Center, L.L.C.
MSHA0320	MA Attachment E-3 & E-4	Humana Medicare	Kingsport Ambulatory Surgery Center, L.L.C.
MSHA0321	MSHA Rate Escalator Effective 1/1/2016 Attachment E-1 & E-2	Humana Commercial	MSHA Hospitals

Reference No.	**Agreement Title**	**Payor**	**Mountain States Health Alliance Contracting Party**
MSHA0322	MA CAH Rate Structure	Humana Medicare	Johnson County Community Hospital

Exhibit 11.10

Insurance Contracts and Payor Agreements in Place at the Time of the Application

Wellmont Health System

Reference No.	**Agreement Title**	**Payor**	**Wellmont Health System Contracting Party**
WHS001	Physician Hospital Organization Agreement (as amended)	Aetna Health, Inc.	Highlands Wellmont Health Network, Inc.
WHS002	Facility Agreement - Non-Acute (as amended)	Anthem Health Plans of Virginia, Inc.	Holston Valley Ambulatory Surgery Center, Sapling Grove Surgery Center, Bristol Surgery Center
WHS003	Hospice Provider Agreement	Southeast Services, Inc.	Wellmont Hospice
WHS004	Anthem Healthkeepers Skilled Nursing Facility Provider Agreement	Healthkeepers, Inc.	Wellmont Health System d/b/a Mountain View Regional Medical Center
WHS005	Anthem Skilled Nursing Facility Medicare Advantage	Southern Services, Inc. and Anthem Health Plans of Virginia, Inc.	Wellmont Health System d/b/a Mountain View Regional Medical Center
WHS006	Anthem Skilled Nursing Facility Provider Agreement	Southeast Services, Inc.	Wellmont Health System d/b/a Mountain View Regional Medical Center
WHS007	Anthem Blue Cross Blue Shield Provider Agreement, as amended-Laboratory EC624	Anthem Blue Cross Blue Shield and Healthkeepers, Inc.	Mountain View Regional Medical Center
WHS008	Anthem Blue Cross and Blue Shield Facility Agreement	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield	Wellmont Health System
WHS009	Anthem Blue Cross and Blue Shield Provider Agreement and Amendment to Anthem Blue Cross and Blue Shield	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield	Lonesome Pine Hospital

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
	Provider Agreement - Therapy EC 612	(Anthem)	
WHS0010	Amendment to Anthem Blue Cross and Blue Shield Provider Agreement	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield	Wellmont Cardiology Services
WHS0011	Letter of Agreement	Anthem Blue Cross and Blue Shield	Wellmont Cardiology Services
WHS0012	Anthem Blue Cross and Blue Shield Provider Agreement - Specialists - EC308A	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Cardiology Services d/b/a Wellmont CVA
WHS0013	Anthem Blue Cross and Blue Shield Provider Agreement - Primary Care Physician - EC104A	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Medical Associates
WHS0014	Amendment 4 to the BluePreferred Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Holston Valley Ambulatory Surgery Center
WHS0015	Amendment 4 to the BlueSelect Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Holston Valley Ambulatory Surgery Center
WHS0016	Amendment 5 to the BluePreferred Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Bristol Surgery Center
WHS0017	Amendment 5 to the BlueSelect Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Bristol Surgery Center

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0018	Amendment 6 to the BluePreferred Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Sapling Grove Surgery Center
WHS0019	Amendment 6 to the BlueSelect Network Ambulatory Surgical Facility Attachment	BlueCross BlueShield of Tennessee, Inc.	Sapling Grove Surgery Center
WHS0020	Swing Bed Facility Amendments to the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc.	Hancock County Hospital
WHS0021	Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates	Wellmont Health System
WHS0022	Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates	Highlands Wellmont Health Network
WHS0023	CoverKids Amendment to the BlueCare Attachment	BlueCross BlueShield of Tennessee, Inc., participating TennCare provider, BCBST's wholly owned HMO subsidiary, Volunteer State Health Plan, Inc.	Wellmont Health System
WHS0024	Rate Variation Amendment to the BlueCare Network Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc., Volunteer State Health Plan, Inc.	Takoma Regional Hospital

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0025	Swing Bed Facility Amendment to the BlueCare Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates; Volunteer State Health Plan, Inc.	Hawkins County Memorial Hospital SNF
WHS0026	Rate Variation Amendment to the BlueCare Network Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc., Volunteer State Health Plan, Inc.	Hawkins County Memorial Hospital
WHS0027	Amendments to the BlueCare Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc., Volunteer State Health Plan, Inc.	Wellmont Health System
WHS0028	Dual Eligible Special Needs Plan Amendment to the BlueCare/TenncareSelect Attachment	BlueCross BlueShield of Tennessee, Inc., Volunteer State Health Plan, Inc.	Wellmont Health System
WHS0029	Swing Bed Facility Amendment to the BlueCare Institution Attachment of the BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates; Volunteer State Health Plan, Inc.	Wellmont Hancock Hospital-Swingbed
WHS0030	BlueCross BlueShield Of Tennessee Institution Agreement, as amended	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates;	Wellmont Health System Facilities: Hawkins County Memorial Hospital Bristol Regional Medical Center Hancock County Hospital Holston Valley Medical Center

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0031	Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates;	Holston Valley Imaging Center
WHS0032	BlueCross BlueShield of Tennessee Group Practice Agreement, as amended	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates;	Cardiovascular Associates, P.C.
WHS0033	Specialist Consulting Amendment to the various Network Group Practice Attachments	BlueCross BlueShield of Tennessee, Inc. and on behalf of its licensed Affiliates;	Cardiovascular Associates, P.C.
WHS0034	Attachment BlueCare Group Practice Specialist to BlueCross BlueShield of Tennessee Group Practice Agreement	Volunteer State Health Plan, Inc.	Wellmont Medical Associates
WHS0035	Attachment BlueCare Group Practice Primary Care to BlueCross BlueShield of Tennessee Group Practice Agreement	Volunteer State Health Plan, Inc.	Wellmont Medical Associates
WHS0036	BlueCross BlueShield of Tennessee Group Practice Agreement (as amended)	BlueCross BlueShield Of Tennessee, Inc. for itself and on behalf of its Affiliates	Wellmont Medical Associates
WHS0037	BluePreferred℠ Network Group Practice Attachment to BlueCross BlueShield of Tennessee Group Practice Agreement (as amended)	BlueCross BlueShield Of Tennessee, Inc. for itself and on behalf of its licensed Affiliates	Wellmont Medical Associates, Inc.
WHS0038	BlueSelect℠ Network Group Practice Attachment to BlueCross BlueShield of Tennessee Group Practice Agreement	BlueCross BlueShield Of Tennessee, Inc. for itself and on behalf of its licensed Affiliates	Wellmont Medical Associates

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0039	Provider Group Services Agreement (with Addendum)	Cigna HealthCare of Tennessee, Inc.	Wellmont Cardiology Services
WHS0040	Provider Group Services Agreement (with Addendum)	Cigna HealthCare of Tennessee, Inc.	Wellmont Medical Associates
WHS0041	Hospital Services Agreement	Cigna HealthCare of Tennessee, Inc.	Wellmont Health System
WHS0042	Hospital Participation Agreement (as amended)	Health Value management, Inc. d/b/a ChoiceCare Network	Wellmont Health System
WHS0043	Hospital Participation Agreement (as amended)	Humana Health Plan, Inc. and Humana Insurance Company and their affiliates that underwrite or administer health plans	Wellmont Health System
WHS0044	Group Participation Agreement (as amended)	Humana Insurance Company, Humana Health Plan, Inc., and their affiliates that underwrite or administer health plans	Wellmont Medical Associates
WHS0045	Model Practice Amendment to Humana Agreement with Wellmont Medical Associates	Humana Health Plan, Inc. and Humana Insurance Company and their affiliates that underwrite and/or administer health plans	Wellmont Medical Associates and Affiliates
WHS0046	Delegation of Credentialing Services Attachment	Humana Insurance Company, Humana Health Plan, Inc.	Highlands Wellmont Network
WHS0047	Letter of Agreement	Humana Insurance Company, Humana Health Plan, Inc. and their affiliates that underwrite or administer health plans	Wellmont Medical Associates

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0048	Delegation of Credentialing Services Attachment	Humana Insurance Company, Humana Health Plan, Inc. and Health Value Management Inc. d/b/a ChoiceCare Network	Wellmont Medical Associates
WHS0049	Amendment One to the Agreement	Humana, Inc.	Wellmont Medical Associates
WHS0050	Delegation Services Addendum to Participation Agreement	Humana Insurance Company, Humana Health Plan, Inc. and Health Value Management Inc. d/b/a ChoiceCare Network	Highlands Wellmont Health Network
WHS0051	Network Access Agreement (as amended)	Bristol Tennessee Essential Services (BTES)	Highlands Wellmont Health Network
WHS0052	Network Access Agreement (as amended)	Carolina Steel/Hirschfeld Steel Companies	Highlands-Wellmont Health Network
WHS0053	Network Access Agreement (as amended)	Electro-Mechanical Corporation	Highlands-Wellmont Health Network, Inc.
WHS0054	Physician Hospital Organization Agreement	Managed Care of America	Highlands Wellmont Health Network
WHS0055	Network Access Agreement (as amended)	Pittston Coal Management Company	Highlands Wellmont Health Network, Inc.
WHS0056	Amendment to Contract Network Access Agreement; also includes executed Business Associate Agreement	Russell County Board of Education	Highlands Wellmont Health Network
WHS0057	Network Access Agreement (as amended)	Scott County School Board	Highlands Wellmont Health Network, Inc.
WHS0058	Network Access Agreement (as amended); also includes executed Business Associate Agreement	Adventist Health System/Sunbelt, Inc. d/b/a Takoma Adventist (Later	Highlands Wellmont Health Network, Inc.

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
		Takoma Regional)	
WHS0059	Network Access Agreement (as amended); also includes executed Business Associate Agreement	United Coal Company and later The United Company	Highlands-Wellmont Health Network, Inc.
WHS0060	Network Access Agreement (as amended)	Prisma Fibers, Inc.	Highlands-Wellmont Health Network, Inc.
WHS0061	Network Access Agreement (as amended)	Wellmont Health System	Highlands-Wellmont Health Network, Inc.
WHS0062	Amendment to the Medical Group Participation Agreement	UnitedHealthcare Insurance Company on behalf of itself, UnitedHealthcare of Tennessee, Inc., and United's Affiliates	Cardiovascular Associates, PC
WHS0063	Amendment to Medical Group Participation Agreement	UnitedHealthcare Insurance Company on behalf of itself, UnitedHealthcare of the River Valley, and United's Affiliates	Wellmont Medical Associates and Wellmont Cardiology Services
WHS0064	Practitioner Group Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Cardiology Services
WHS0065	Amendment to Medical Group Participation Agreement	UnitedHealthcare Insurance Company on behalf of itself, UnitedHealthcare of the River Valley, Inc., and United's Affiliates	Wellmont Medical Associates
WHS0066	Tennessee Program Network Practitioner Group Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc. (f/k/a John Deere Health Plan, Inc.)	Wellmont Medical Associates

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0067	Credentialing Delegation Agreement	UnitedHealthcare Insurance Company, on behalf of itself and UnitedHealthcare of the River Valley, Inc. and United Affiliates	Wellmont Medical Associates
WHS0068	Amendment to the Medical group Participation Agreement	UnitedHealthcare Insurance Company on behalf of itself, UnitedHealthcare of Tennessee, Inc., and United's Affiliates	Cardiovascular Associates, PC
WHS0069	Medical Group Participation Agreement	UnitedHealthcare Insurance Company contracting on behalf of itself, UnitedHealthcare of the River Valley, Inc., and the other entities that are United's Affiliates	Wellmont Medical Associates
WHS0070	Amendment to Agreement of Tennessee Program Network Group Practitioner Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Medical Associates
WHS0071	Amendment to the Agreement of Tennessee Program Network Hospital Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Health System on behalf of Bristol Regional Medical Center, Holston Valley Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Hawkins County Medical Center, Mountain View Regional Medical Center, Takoma Regional Hospital, Wellmont Hospice, Holston Valley Imaging Center, Bristol Surgery Center, Holston Valley, Surgery Center and Sapling Grove Surgery Center

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0072	Facility Participation Agreement	UnitedHealthcare Insurance Company, contracting on behalf of itself, UnitedHealthcare Plan of the River Valley, Inc. and the other entities that are United's Affiliates	Wellmont Health System
WHS0073	Amendment to the Agreement of Tennessee Program Network Hospital Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Health System on behalf of Bristol Regional Medical Center, Holston Valley Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Hawkins County Medical Center, Mountain View Regional Medical Center, Takoma Regional Hospital, Wellmont Hospice, Holston Valley Imaging Center, Bristol Surgery Center, Holston Valley, Surgery Center and Sapling Grove Surgery Center
WHS0074	Tennessee Program Network Hospital Provider Agreement (as amended)	UnitedHealthcare Plan of the River Valley, Inc.	Wellmont Health System on behalf of Bristol Regional Medical Center, Holston Valley Medical Center, Lonesome Pine Hospital, Hancock County Hospital, Hawkins County Medical Center, Mountain View Regional Medical Center, Takoma Regional Hospital, Wellmont Hospice, Holston Valley Imaging Center, Bristol Surgery Center, Holston Valley, Surgery Center and Sapling Grove Surgery Center
WHS0075	**FOLDER: Wexford House Agreements**		
WHS0076	Outsourcing Therapy Services	Rehab Solutions, Inc.	RHA Sullivan, Inc. d/b/a The Wexford House

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
	Agreement		
WHS0077	**Anthem Folder**		
WHS0078	Amendment to the Skilled Nursing Facility Provider Agreement	Southeast Services, Inc. and Anthem Blue Cross Blue Shield	Generic notice to all participating providers
WHS0079	Amendment to Skilled Nursing Facility Provider Agreement	Southeast Services, Inc. and Anthem Blue Cross Blue Shield	Generic notice to all participating providers
WHS0080	Skilled Nursing Facility Agreement	Trigon Services, Inc.	The Wexford House
WHS0081	**HWHN**		
WHS0082	Business Associate Agreement	Wellmont Wexford House	Highlands Wellmont Health Network
WHS0083	Preferred Provider Agreement	Wellmont Wexford House	Highlands Wellmont Health Network, Inc.
WHS0084	**BCBST**		
WHS0085	Network P Skilled Nursing Facility Attachment of the Blue Cross Blue Shield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc. for itself and on behalf of other Payors, including its Affiliates	The Wexford House
WHS0086	2009 BlueCare Compliance Amendment	BlueCross BlueShield of Tennessee, Inc. and Volunteer State Health Plan, Inc.	Generic regulatory amendment to all participating providers
WHS0087	Long Term Care Services Nursing Facility Agreement (as amended)	Volunteer State Health Plan, Inc. for itself and on the behalf of its Affiliates	The Wexford House
WHS0088	Medicare Advantage Provider Agreement	BlueCross BlueShield of Tennessee, Inc.	The Wexford House
WHS0089	BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee on behalf of its licensed Affiliates	The Wexford House

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0090	Network S Skilled Nursing Facility Attachment of the Blue Cross Blue Shield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc. for itself and on behalf of other Payors, including its Affiliates	The Wexford House
WHS0091	BlueAdvantage Local PPO Medicare Advantage Provider Agreement Skilled Nursing Facility Attachment (as amended)	BlueCross BlueShield of Tennessee, Inc., for itself and on behalf of its licensed Affiliates	The Wexford House
WHS0092	Skilled Nursing Facility Network Attachment	BlueCross BlueShield of Tennessee on behalf of itself and its Affiliates	The Wexford House
WHS0093	**Humana**		
WHS0094	Ancillary Provider Participation Agreement	Health Value Management, Inc. d/b/a ChoiceCare Network	RHA Sullivan, Inc.
WHS0095	**UHC**		
WHS0096	Amendment to Tennessee Program Network Ancillary Provider Agreement	UnitedHealthCare Plan of the River Valley, Inc.	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0097	Tennessee Program Network Ancillary Provider Agreement	UnitedHealthcare Plan of the River Valley, Inc.	RHA Sullivan d/b/a The Wexford House
WHS0098	Ancillary Provider Participation Agreement	United Healthcare Insurance Company, on behalf of itself, UnitedHealthcare of Tennessee, Inc., and United's Affiliates	The Wexford House
WHS0099	Free Standing Skilled Nursing Facility Medicare Payer Appendix AND Amendment to Ancillary Provider Participation Agreement	United HealthCare Insurance Company, on behalf of itself and United's Affiliates	The Wexford House

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0100	Memorandum of Agreement	The Center for Healthcare Quality	The Wexford House
WHS0101	First Amendment to the Ancillary Service Provider Agreement	HealthSpring of Tennessee, Inc. and HealthSpring Life and Health Insurance Company, Inc.	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0102	Ancillary Service Provider Agreement	HealthSpring of Tennessee, Inc. and HealthSpring Life and Health Insurance Company, Inc.	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0103	Medical Assistance Participation Agreement (Medicaid/TennCare Title XIX Program)	The State of Tennessee Department of Finance and Administration Bureau of TennCare	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0104	Skilled Nursing Facility Participation Agreement	Tricare	RHA Sullivan, Inc. d/b/a The Wexford House
WHS0105	Network Access Agreement (as amended)	ACS Consulting	Highlands Wellmont Health Network, Inc.
WHS0106	Physician Hospital Organization Agreement	A & G Healthcare Services d/b/a Amera-Net	Highlands Wellmont Health Network
WHS0107	Physician-Hospital Organization Agreement	American PPO, Inc.	Highlands Wellmont Health Network
WHS0108	Physician-Hospital Organization Agreement (as amended)	Beech Street Corporation	Highlands Wellmont Health Network
WHS0109	Institutional Services Agreement (as amended)	CIGNA Behavioral Health, Inc.	Wellmont Health System, Inc.
WHS0110	Physician Hospital Organization Agreement	CorVel Corporation	Highlands Wellmont Health Network

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
	(as amended)		
WHS0111	Facility Agreement	Employer's Choice Network, LLC	Highlands Wellmont Health Network on behalf of Lonesome Pine Hospital, Lee Regional Medical Center and Mountain View Regional Medical Center
WHS0112	PHO Agreement	Evolutions Healthcare Systems, Inc.	Highlands Wellmont Health Network
WHS0113	The First Health Network Hospital Contract (as amended)	The First Health Network	Wellmont Health System d/b/a Wellmont Bristol Regional Medical Center, Wellmont Holston Valley Medical Center, Wellmont Ridgeview Pavilion
WHS0114	Health Care Services Agreement	Galaxy Health Network	Highlands Wellmont Health Network
WHS0115	Provider Participation Agreement (as amended)	Health Net Federal Services, LLC on behalf of itself and the subsidiaries and Affiliates of Health Net, Inc.	Wellmont Health System d/b/a Lonesome Pine Hospital & Mountain View Regional Medical Center
WHS0116	Facility Provider Agreement (as amended)	Health Net Federal Services, LLC	Highlands Wellmont Health Network d/b/a Lonesome Pine Hospital, Lee Regional Medical Center and Mountain View Regional Medical Center
WHS0117	HMHS South Hospital Service Agreement (as amended)	Humana Military Healthcare Services, Inc.	Wellmont Bristol Regional Medical Center Wellmont Bristol Regional Medical Center-SNF Wellmont Home Care Wellmont Home Medical Equipment and Respiratory Services Wellmont Infusion Network Wellmont Hospice Wellmont Holston Valley Medical Center Wellmont Holston Valley Medical Center-SNF

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
			Wellmont Hawkins County Memorial Hospital
WHS0118	Physician Hospital Organization Participation Agreement (as amended)	The Initial Group, Inc.	Highlands-Wellmont Health Network
WHS0119	Network Services Agreement (as amended)	Integrated Medical Solutions, LLC	Highlands Wellmont Health Network
WHS0120	Participating Provider Agreement (as amended)	AMERIGROUP Virginia, Inc. d/b/a AMERIGROUP Community Care	Highlands Wellmont Health Network, Inc.
WHS0121	Facility and Program Participation Agreement (as amended)	Magellan Behavioral Health, Inc.	Wellmont Health System, Inc.
WHS0122	Facility Network Participation Agreement (as amended)	Mental Health Associates, Inc.	Bristol Regional Medical Center, Takoma Regional Hospital and Ridgeview Pavilion
WHS0123	Mountain Empire PACE Provider Agreement (as amended)	Mountain Empire Older Citizens, Inc.	Wellmont Health System, Inc. (d/b/a Lonesome Pine Hospital, Lee Regional Medical Center, Mountain View Regional Medical Center, Holston Valley Medical Center, and Bristol Regional Medical Center)
WHS0124	Health Care Provider Network Agreement Physician-Hospital Organization (as amended)	BCE Emergis Corporation	Highlands Wellmont Health Network
WHS0125	Physician Hospital Organization Agreement (as amended)	NovaNet, Inc.	Highlands Wellmont Health Network
WHS0126	Physician Hospital Organization Agreement (as amended)	Prime Health Services, Inc.	Highlands Wellmont Health Network
WHS0127	Physician Hospital Organization Agreement (as amended)	Provider Strategies, Inc. (n/k/a Provider Select, Inc.)	Highlands Wellmont Health Network

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0128	Network Access Agreement (as Amended)	Acordia National, Inc.	Highlands Wellmont Health Network, Inc.
WHS0129	Physician Hospital Organization Agreement (as amended)	Southern Health Services, Inc.	Highlands Wellmont Health Network
WHS0130	United Behavioral Health Provider Agreement (as amended)	United Behavioral Health, Inc.	Wellmont Health System d/b/a Bristol Regional medical Center-Ridgeview Pavilion added 10/1/2004
WHS0131	United Behavioral Health TennCare Program Facility Participation Agreement	United Behavioral Health on behalf of itself and UnitedHealthcare Plan of the River Valley	Wellmont Health System d/b/a Bristol Regional Medical Center, Ridgeview Pavilion and Takoma Regional Hospital
WHS0132	Agreement and Addendum to the Funds Cooperating Provider Agreement	The Trustees of the United Mine Workers of America Combined Benefit Fund, the Trustees of the UMWA 1992 Benefit Plan and the Trustees of the UMWA 1993 Benefit Plan	Wellmont Health System
WHS0133	Physician Hospital Organization Agreement (as amended)	USA Managed Care Organization, Inc.	Highlands Wellmont Health Network
WHS0134	Hospitalization Services Agreement (Fee-For-Services)	Commonwealth of Virginia Department of Rehabilitation Services	Wellmont-Bristol Regional Medical Center, Holston Valley Medical Center and Lonesome Pine Hospital
WHS0135	Administrative Contract (as amended)	Virginia Premier Health Plan, Inc.	Highlands Wellmont Health Network
WHS0136	Facility Amendment Schedule (as amended)	ValueOptions, Inc.	Wellmont Bristol Regional Medical Center
WHS0137	Diagnostic Service Agreement	Veterans Evaluation Services	Wellmont Health System

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0138	Physician Hospital Organization Provider Participation Agreement	Windsor Health Plan, Inc.	Highlands Wellmont Health Network
WHS0139	Rates Only Amendment to Hospital Service Agreement (06/07/2014)	Cigna HealthCare of Tennessee, Inc.	Wellmont Health System
WHS0140	Amendment 4 to the BluePreferred Network Institution Attachment	Blue Cross Blue Shield of Tennessee, Inc. on behalf of itself and its licensed Affiliates	Takoma Regional Hospital Hawkins County Memorial Hospital Bristol Regional Medical Center Hancock County Hospital Holston Valley Medical Center
WHS0141	Amendment 4 to the BlueSelect Network Institution Attachment	Blue Cross Blue Shield of Tennessee, Inc. on behalf of itself and its licensed Affiliates	Takoma Regional Hospital Hawkins County Memorial Hospital Bristol Regional Medical Center Hancock County Hospital Holston Valley Medical Center
WHS0142	Medicare Advantage Provider Agreement (as amended)	BlueCross BlueShield of Tennessee, Inc. for itself and on behalf of its licensed Affiliates	Wellmont Cardiology Services
WHS0143	Medicaid Specialist Center Agreement	HealthKeepers, Inc.	Wellmont Medical Associates, Inc.
WHS0144	Medicaid Primary Care Physician Center Agreement	HealthKeepers, Inc.	Wellmont Medical Associates, Inc.
WHS0145	Amendment to Anthem Blue Cross and Blue Shield Provider Agreement Signature Page	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Medical Associates
WHS0146	Signature Page	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Medical Associates

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0147	Anthem Blue Cross Blue Shield Provider Agreement-Laboratory	Southeast Services, Inc.	Mountain View Regional Medical Center
WHS0148	Amendment to Anthem Blue Cross and Blue Shield Provider Agreement	Anthem health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield	Wellmont Medical Associates
WHS0149	2015 Rate Variation Amendment to the BlueCare/TennCareSelect Network Attachment	BlueCross BlueShield of Tennessee, Inc.	Hawkins County Memorial Hospital
WHS0150	2015 Rate Variation Amendment to the BlueCare/TennCareSelect Network Attachment	BlueCross BlueShield of Tennessee, Inc.	Hawkins County Memorial Hospital
WHS0151	2015 Rate Variation Amendment to the BlueCare/TennCareSelect Network Attachment	BlueCross BlueShield of Tennessee, Inc.	Holston Valley Medical Center
WHS0152	P4 Pathways Amendment to the BlueCare Network Group Practice attachment	BlueCross BlueShield of Tennessee, Inc. and Volunteer State Health Plan, Inc.	Wellmont Medical Associates
WHS0153	P4 Pathways Amendment to the BluePreferred Network Group Practice Attachment	BlueCross BlueShield of Tennessee, Inc.	Wellmont Medical Associates
WHS0154	P4 Pathways Amendment to the BlueSelect Network Group Practice Attachment	BlueCross BlueShield of Tennessee Inc.	Wellmont Medical Associates
WHS0155	P4 Pathways Amendment to the BlueCoverTN Amendment to the BluePreferred Network Group Practice Attachment	BlueCross BlueShield of Tennessee Inc.	Wellmont Medical Associates

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0156	P4 Pathways Amendment to the TennCare Select Network Group Practice Attachment	BlueCross BlueShield of Tennessee, Inc. and Volunteer State Health Plan, Inc.	Wellmont Medical Associates
WHS0157	Anthem Blue Cross and Blue Shield Provider Agreement (Specialists-EC308A)	Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and Healthkeepers, Inc.	Wellmont Medical Associates
WHS0158	BlueCross BlueShield of Tennessee Hospital Pay-for-Performance Program Guide	BlueCross BlueShield of Tennessee Inc.	THIS IS NOT A CONTRACT
WHS0159	BlueCross BlueShield of Tennessee Institution Agreement	BlueCross BlueShield of Tennessee, Inc., for itself and on behalf of its wholly-owned subsidiaries	Wellmont Health Systems
WHS0160	BlueCross BlueShield of TN Schedule 1-A	BlueCross BlueShield of Tennessee Inc.	Wellmont Health Systems
WHS0161	BlueCross BlueShield of Tennessee Outpatient Surgery Groupers Attachment 2-A, Schedule	BlueCross BlueShield of Tennessee Inc.	Wellmont Health Systems
WHS0162	BlueCross BlueShield of Tennessee Laboratory Schedule 2-B	BlueCross BlueShield of Tennessee Inc.	Wellmont Health Systems

Reference No.	Agreement Title	Payor	Wellmont Health System Contracting Party
WHS0163	Amendment to the Institution Agreement	BlueCross BlueShield of Tennessee, for itself and on behalf of its licensed Affiliates	Wellmont Health System and following facilities: Bristol Regional Medical Center; Hawkins County Memorial Hospital; Holston Valley Medical Center; Hancock County Hospital; Bristol Surgery Center; Holston Valley Ambulatory Surgery Center; Sapling Grove Surgery Center

Exhibit 11.11

Information regarding existing and future business plans of Mountain States is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

Exhibit 11.12

Information regarding existing and future business plans of Wellmont is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

EXHIBIT 11.13

NEW HEALTH SYSTEM ALIGNMENT POLICY

Alignment of Clinical Facilities and Clinical Services by health systems, where appropriate, are a standard and widely accepted mechanism for reducing unnecessary cost in health care, improving quality, and ensuring the services and programs offered are continuously evaluated objectively to ensure efficiency and the best outcome for patients. Among the many benefits of proper alignment are:

1. Assembling a "critical mass" of technology, clinical expertise and financial resources required to develop true centers of excellence.
2. Freeing up resources needed to provide highly technical and resource intensive services that, at a given time, may only be accessed outside the region.
3. Providing financial resources to clinical services that operate at a loss, or are currently not adequately provided, but are vitally important to the health of the region.
4. Improving the financial and clinical performance of services or facilities that currently operate in close proximity of each other.
5. Ensuring overall system financial viability, with an understanding that low overall operating margins inhibit the ability of the system to capitalize and invest in other services important to the region.
6. Realignment of care will improve access and care delivery, and provide effective care at the right locations.

Policy: Alignment of clinical facilities and/or services, where appropriate, may occur after an evaluation of the potential merits and adverse effects related to access, quality and service for patients. The objective of any alignment should include, but may not be limited to: enhanced service to the region, improved quality or scope of care, or enhanced financial performance material to the success of the overall system. Prior to implementing an alignment, it must be determined the benefits of the alignment outweigh the adverse effects.

Application: This policy applies to alignment of clinical facilities and clinical services in those cases where the alignment results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in that community. This policy is not applicable to alignment of administrative or non-clinical services or programs.

Definitions:

Clinical Facility or Facilities - Any location where inpatient care is provided.

Clinical Service –A scope of patient care generally recognized to be associated with a specific medical or surgical specialty.

Community – The primary service area of a clinical service or facility, generally defined as the area from which 75% of patient volume originates.

Region – the geographic area served by the New Health System

Board Integration Committee – A committee of the Board which shall meet as needed upon a proposal by management to align a facility or service applicable under this policy. The purpose of the committee shall be to evaluate management's recommendation, and make a recommendation to the Board of Directors prior to the Board's final approval or rejection of a proposed alignment.

Procedure:

1. Management identifies an opportunity (or opportunities) for alignment which meets the requirement for review as outlined herein.
2. Management will evaluate the opportunity based upon (a) the use of clinical and financial data, and (b) input from physicians and other clinicians relevant to the service or facility which is subject of the alignment. Management will identify the benefits and adverse effects of the proposed alignment, including any cultural impacts. Management may utilize consulting and other independent resources to assist in the evaluation.
3. Upon reaching a conclusion to move forward with alignment, management will notify the Board of its intent, and will request a meeting of the Board Integration Committee. Management will present the proposal for the alignment to the Board Integration Committee.
4. The Board Integration Committee will evaluate the proposal, including the data and input relied upon by management in making its proposal. The Board Integration Committee will formulate a recommendation to the Board of Directors.
5. In considering the recommendation of the Board Integration Committee, the Board shall evaluate the data and input relied upon by the Board Integration Committee, including any data or input which does not support the recommendation.
6. Management shall provide administrative and analytical support to the Board Integration Committee as it contemplates any proposed action.
7. Upon approval by the Board of any alignment, management shall report periodically to the Board Integration Committee on the status of the alignment effort for each project approved, until such project has been completed.

8. One year after the completion of an alignment, management will provide a report to the Board on the results of the alignment, including any lessons learned, physician feedback, community effects and financial impact.

Charter of the Board Integration Committee

Membership. The Board Integration Committee will consist of 10 members (the "Members"), composed of the following:

A. Six (6) Members shall be non-management Directors, two (2) of whom shall be physicians.
B. Four (4) Members shall be at-large members who are not Directors and who are not otherwise serving on any committees of the Board of Directors. At least two (2) at-large Members shall be independently practicing physicians.

The Members will be nominated by the Board Governance/Nominating committee, except that the two (2) at-large physician Members will be nominated by the Clinical Council. The initial membership of the Board Integration Committee shall be composed of equal representation from legacy Wellmont Health System and Mountain States Health Alliance until after the second anniversary of the closing of the merger transaction.

1. The Board Integration Committee shall endeavor to ensure management, in making a recommendation to align a service or facility, has deployed a planning process which includes objective financial and clinical data and research, as well as input from affected physicians, clinicians, and other affected stakeholders. The committee will insure a clear vision is articulated by management, including the goals and objectives of the alignment. The committee will evaluate potential community impact of proposed alignment in terms of health status, access, employment and other community considerations.

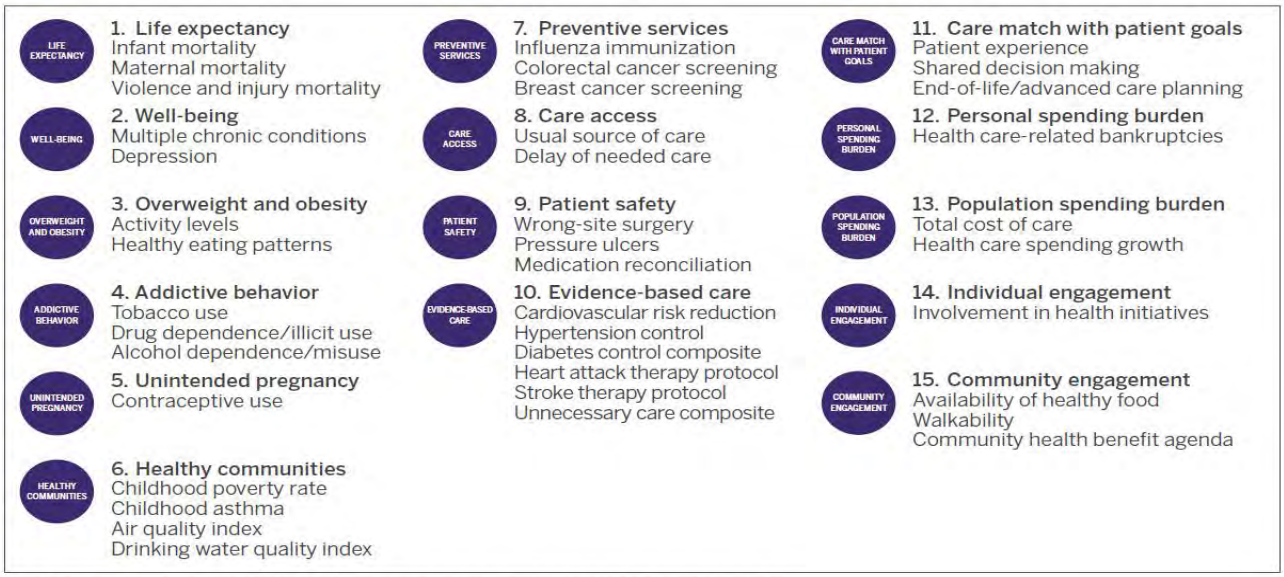
2. The Board Integration Committee may request that management establish an inventory of current facilities and services and request recommendations for where potential overlap exists and/or synergies could be realized.

3. The Board Integration Committee will ensure management has developed a communication plan and strategy for implementation that considers the various stakeholders affected by any such decision to align a facility or service.

Exhibit 11.14

Overview of IOM Core Metrics: The Institute of Medicine (IOM) recently released a set of core metrics for guidance in population health for use by governments, health systems, insurers, businesses and health departments. (Institute of Medicine, 2015, *Vital signs: Core metrics for health and health care progress*, Washington, D.C.: The National Academies Press) There are 15 core measures grouped into four domains: Healthy People, Care Quality, Care Cost, and Engaged People. Measures within each domain include: *Healthy people*: Life expectancy, well-being, overweight and obesity, addictive behavior, unintended pregnancy, healthy communities; *Care quality*: Preventive services, care access, patient safety, evidence-based care, care match with patient goals; *Care cost*: Personal spending burden, sustainability; *Engaged people*: Individual engagement, community engagement. The IOM report also identified best available measures for each core metric and reported the current national values.

IOM Core Measures



Source: Adapted from the Institute of Medicine (IOM), 2015, *Vital Signs: Core metrics for health and health care progress*. Washington, D.C.: The National Academies Press.

IOM Core Measure Set

Domain	Key Element	Core Measure Focus	Best Current Measure	Current National Performance
Healthy People	Length of Life	Life Expectancy	Life expectancy at birth	79 year life expectancy at birth
	Quality of Life	Wellbeing	Self-reported health	66% report being healthy
	Healthy Behaviors	Overweight and Obesity	Body mass index	69% of adults with BMI >25
		Addictive Behavior	Addiction death rate	200 addiction deaths per 100,000, age 15+
		Unintended Pregnancy	Teen pregnancy rate	27 births per 1,000 females aged 15 to 19
	Healthy Social Circumstances	Healthy Communities	High school graduation rate	80% graduate in 4 years
Care Quality	Prevention	Preventive Services	Childhood immunization rate	68% of children vaccinated by age 3
	Access to Care	Care Access	Unmet care need	5% report unmet medical needs
	Safe Care	Patient Safety	Hospital acquired infection rate	1,700 HAIs per 100,000 admissions
	Appropriate Treatment	Evidence-Based Care	Preventable hospitalization rate	10,000 avoidable per 100,000 admissions
	Person-Centered Care	Care Match with Patient Goals	Patient-clinician communication satisfaction	92% satisfied with provider communication
Care Cost	Affordability	Personal Spending Burden	High spending relative to income	46% spent >10% income on care, or uninsured in 2012
	Sustainability	Population Spending Burden	Per capita expenditures on health care	$9,000 health care expenditure per capita
Engaged People	Individual Engagement	Individual Engagement	Health literacy rate	12% proficient health literary
	Community Engagement	Community Engagement	Social support	21% inadequate social support

Source: Adapted from the Institute of Medicine's *Vital Signs: Core Metrics for Health and Health Care Progress*. Table S1-Core Measure Set. Available online at: **http://www.iom.edu/Reports/2015/Vital-Signs-Core-Metrics.aspx**

Exhibit 15.1

Plan of Separation
between
Wellmont Health System
and
Mountain States Health Alliance

Pursuant to Grant of Certificate of Public Advantage
By the Tennessee Commissioner of Health

This Plan of Separation ("the Plan") is prepared as part of the application for Certificate of Public Advantage ("COPA") submitted jointly by Wellmont Health System and Mountain States Health Alliance (collectively "the Parties") to the Honorable Dr. John J. Dreyzehner, Commissioner, Tennessee Department of Health ("the Commissioner"). The Plan is intended to set out the process by which the Parties would effect an orderly separation of the new, integrated health system to be created under the COPA (the "New Health System") in the event that the Commissioner determines that it is necessary to terminate the COPA previously granted to the Parties, as set forth in T.C.A. section 68-11-1303(g).

Upon written notice of a determination by the Commissioner to terminate the COPA pursuant to T.C.A. section 68-11-1303(g), and upon expiration of any period to appeal, or a final ruling adverse to the Parties on appeal, the Parties shall, within thirty (30) days, retain a consultant with expertise in provider operations and competition in the health care industry ("the Consultant"). The Consultant shall assist the Parties in complying with the termination order by analyzing competitive conditions in the markets subject to the Commissioner's termination order and identifying the specific steps necessary to return the markets to their pre-consolidation competitive state. In undertaking this analysis, the Parties and Consultant shall take into account data submitted in the COPA Application showing the structure of the geographic service area at the time of consolidation, including the number, locations and relative shares of the parties and all other participants. The Parties and Consultant will cooperate with the Commissioner in these efforts. This cooperation shall include, upon the Commissioner's request, sharing any non-privileged documents, data or other information that the Parties or Consultant may receive, generate or evaluate in the course of this process.

By agreeing that the Consultant will cooperate and share information with the Commissioner, the Parties hereby neither expressly nor implicitly waive any rights they may have with regard to maintaining protections for the privileged, confidential or proprietary content within said information. It is the Parties' intent to properly manage competitively sensitive information, and thus, to maintain the privileged, confidential and/or proprietary nature of those items and not subject them to public disclosure.

With the assistance from the Consultant, within one hundred (100) days of the Consultant's retention date, the Parties will submit a plan to the Commissioner for divestiture of assets and operations and any other actions that would be appropriate under then-current market circumstances designed to restore, to the extent reasonably practicable, competitive conditions to their pre-consolidation competitive state or otherwise remedy the competitive concerns identified by the Commissioner ("Proposed Plan"). The Proposed Plan will be accompanied by a written report from the Consultant concerning the suitability of the proposed disposition of assets and operations in addressing the competitive deficiencies that resulted in the termination order. The Parties and Consultant will cooperate with the Commissioner in his or her examination and evaluation of the Proposed Plan.

Immediately upon the Commissioner's approval of the Proposed Plan (or of any plan that contains revisions thereto) ("Final Plan"), the Parties shall undertake to execute the Final Plan. Unless the Parties and the Commissioner agree it is not feasible to do so, the Parties will finalize execution of the Plan within two hundred forty (240) days from the date of receipt of written approval by the Commissioner of the Final Plan.

The Proposed Plan may include the following components, absent any then-existing circumstances that would likely negate the effectiveness of said components in restoring competition to its pre-consolidation state:

- Divestiture, into a separate and independent enterprise, of those facilities and other assets of the New Health System that are necessary to establish competition with said enterprise and restore, to the extent reasonably practicable, competitive conditions as they existed immediately prior to the merger in the markets subject to the termination order, along with all rights, title and interest in said assets, as well as applicable associated items including underlying real property, inventories, third-party contracts, names and trademarks, governmental consents, books and records and technologies that are essential to the operation of said assets as a going concern;

- Enablement of physician and non-physician employees of the Parties to be recruited to and employed by the owner of the divested assets, without regard to then-existing contractual restrictions on such recruitment or employment;

- Enablement of any physician to be recruited to, under contract with, and/or extended medical staff privileges by the owner of the divested assets, without regard to then-existing contractual restrictions on such recruitment, contractual relationships, or staff privileges;

- Assignment of any third-party contracts necessary to maintain ongoing, uninterrupted operation of the divested assets, along with cooperation and assistance in obtaining any third-party approvals that are required for such assignments;

- Provision, as needed, of transitional services for up to six months to the owner of the divested assets in the areas of administration, operations, information technology and clinical care, to ensure that the new competitive entity provides health care services with substantially the same level of quality and efficiency as the Parties;

- Maintenance of the same level of administrative, operational and clinical quality of all assets and operations that existed on the day before receipt of the Commissioner's termination order through the period until obligations under the Plan of Separation expire; and

- Establishment of firewalls and other protective procedures to the extent necessary to enable a separate and independent apparatus for payer contracting by the new competitive entity.

Should the Commissioner believe that it would be beneficial, the Parties will provide for the Commissioner's benefit an independent third-party health care expert to serve as a monitor ("the Monitor") for the Plan of Separation. The New Health System would provide the funding for the Monitor.

Through the Monitor, the Commissioner could engage with the Consultant and the Parties to ensure the State's interests are served. The Monitor would be responsible for ensuring the orderly implementation of the Plan and for providing regular input to the Parties and feedback to the Commissioner.

Should the Parties not fully execute the Plan within the above stated two hundred forty (240) day period, then the Commissioner may require that a Trustee be installed to take over the process of implementing and finalizing the Plan. The Monitor could serve in this role, or another party experienced in the health care industry could be engaged to serve in the role. In either event, the New Health System will be responsible for the costs associated with engaging the Trustee, and the fees and expenses associated with the Trustee's work.

Exhibit 15.2

Opinion on the Plan of Separation

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fticonsulting.com

February 10, 2016

Dr. John J. Dreyzehner
Commissioner, Tennessee Department of Health
710 James Robertson Parkway
Nashville, Tennessee 37243

RE: Review of the Plan of Separation filed under the Application for Certificate of Public Advantage ("COPA") by Mountain States Health Alliance and Wellmont Health System

Dear Dr. Dreyzehner:

FTI Consulting ("FTI") has completed an independent review of the above referenced Plan of Separation between Wellmont Health System and Mountain States Health Alliance (collectively "The Parties") filed under the COPA Application. The remainder of this letter details the objectives of our review, the findings from our review, and the limitations of this letter.

Objective of the Analysis

The objective of our independent review of the Plan of Separation (the "Plan") was to assess if the Plan could be operationally implemented without undue disruption to essential health services provided by the Parties. To perform our work, FTI reviewed the following documents/materials:

- Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report, January 7, 2016.
- New Health System Alignment Policy.
- Certificate of Public Advantage, State of Tennessee, Application.
- Exhibit 15.1, Plan of Separation, COPA, State of Tennessee, Application.

Background on FTI Consulting

Founded in 1982, FTI Consulting has over 4,400 professionals in 80 cities around the globe. We are a publicly company traded on the NYSE (FCN), and we have an enterprise value in excess of $1.7 B. FTI has experts in 16 industry specialties who provide advisory services to all 10 of the world's top bank holding companies, 94 of the world's top 100 law firms, and 47 of the Fortune 100 corporations. FTI has been built to address the full range of interrelated issues that can affect enterprise value.

FTI's Health Solutions practice consists of over 300 professionals including clinicians, healthcare executives, strategists, and functional specialists located in 27 offices across the United States. Most of

our Health Solutions executives have more than 25 years of experience leading health systems, hospitals, and physician organizations; designing and implementing enhanced performance programs; and performing complex healthcare operational and financial analyses.

We advise clients on all aspects of provider performance improvement and planning, and tailor our recommendations to focus on solutions that we believe are most appropriate for each specific client situation. We have also worked with clients as they look to combine services, as well as divest them. In the past three years, we have worked with over 180 healthcare industry clients (Health Systems, Medical Groups, Academic Medical Centers) on a variety of projects.

Findings from the Analysis

In reviewing the Pre-Submission Report and the COPA Application, FTI noted that the inpatient hospitals, other patient care facilities, and ancillary entities specifically included in the proposed combination by the Parties can be clearly delineated as to which Party "contributed" the facility to the new combined entity. This delineation can be used as part of a common basis for developing plans for returning contributed assets and services to their pre-consolidation competitive state should the Plan of Separation be triggered.

FTI reviewed the New Health System Alignment Policy, and noted the following:

- The New Health System will evaluate opportunities for alignment of clinical facilities and clinical services provided by the parties based upon use of clinical and financial data, and inputs from physicians and other clinicians relevant to the service or facility which is the subject of the alignment.

- New Health System Management will identify the benefits and adverse effects of the proposed alignment.

- A New Health System Board Integration Committee will evaluate the proposals for alignment, including the data and inputs relied upon by Management, in formulating their recommendations for alignment.

- The New Health System Board Integration Committee will monitor the status of approved alignment efforts through periodic Management reporting. Furthermore, one year after the completion of the alignment, management will provide a report to the New Health System Board identifying lessons learned, physician feedback, community benefits and financial impact.

- The alignment process and all related analyses, studies, inputs, reporting, and other monitoring activities can also be used in developing plans for returning contributed assets and services to their pre-consolidation competitive state should the Plan of Separation be triggered.

Finally, FTI reviewed the Plan of Separation filed in the COPA Application itself, and noted the following:

- The specified intention of the Plan is to set out the process by which the Parties would effect an orderly separation of the New Health System created under the COPA, in the event that the

Commissioner determines it is necessary to terminate the COPA previously granted to the Parties, as set forth in T.C.A. section 68-11-1303(g).

- The Plan of Separation calls for the retention of a consultant with expertise in provider operations and competition in the healthcare industry to assist in complying with any termination order issued by the Commissioner of the Tennessee Department of Health.

    - The Consultant will be asked to analyze the competitive conditions in the market(s) subject to the Commissioner's termination order, and to identify the specific steps necessary to return the market(s) to their pre-consolidation competitive state. The Consultant will also be asked to take into account the data submitted in the COPA Application showing the structure of the geographic service area at the time of the consolidation.

    - The Consultant will assist the Parties in developing a plan to be submitted to the Commissioner for divestiture of assets and operations and any other actions that would be appropriate under then-current market circumstances designed to restore, to the extent reasonably practicable, competitive conditions to their pre-consolidation competitive state or otherwise remedy the competitive concerns identified by the Commissioner.

    - The final plan for divestiture and other actions must be approved by the Commissioner. FTI notes that the final plan will include a number of reasonable and prudent components outlined below in this letter, but not limited to:

        - Divestiture, into a separate and independent enterprise, of those facilities and other assets of the New Health System that are necessary to establish competition with said enterprise and restore, to the extent reasonably practicable, competitive conditions as they existed immediately prior to the merger in the markets subject to the termination order.

        - Enablement of physician and non-physician employees of the Parties to be recruited to and employed by the owner of the divested assets, without regard to then-existing contractual restrictions on such recruitment or employment.

        - Enablement of any physician to be recruited to, under contract with, and/or extended medical staff privileges by the owner of the divested assets, without regard to then-existing contractual restriction on such recruitment, contractual relationships, or staff privileges.

        - Assignment of any third-party contracts necessary to maintain ongoing, uninterrupted operation of the divested assets, along with cooperation and assistance in obtaining any third-party approvals that are required for such assignments.

        - Provision, as needed, of transitional services for up to six months to the owner of the divested assets in the areas of administration, operations, information technology and clinical care, to ensure that the new competitive entity provides health care services with substantially the same level of quality and efficiency as the Parties.

- Maintenance of the same level of administrative, operational and clinical quality of all assets and operations that existed on the day before receipt of the Commissioner's termination order through the period until obligations under the Plan of Separation expire.

- FTI noted that, under the Plan of Separation, the Commissioner has the ability to trigger the use of an independent third-party monitor, funded by the Parties, should the Commissioner determine that the use of such would be beneficial.

- A Trustee can also be named by the Commissioner under the Plan of Separation to take over the process of implementing the divestiture plan should the plan not be executed within 240 days after the termination order is issued.

- FTI further noted that the Plan of Separation must be updated on an annual basis, and that an evaluation and/or analysis of the Plan of Separation must also be conducted by an independent third party, knowledgeable in the healthcare industry and provider operations, on an annual basis.

Based on our experience as healthcare industry consultants, the above observations, and the findings derived from our review of the relevant documents, we believe that the Pre-Submission Report, The New Health System Alignment Policy, the COPA Application, and The Plan of Separation can serve as the basis for an effective process to restore competition to the pre-consolidation competitive state through an orderly transition that can be operationally implemented without undue disruption to the essential health services provided by the Parties so long as all appropriate clinical, operational, legal and other applicable guidelines and statutes are also followed.

Limitations of This Letter

This letter is only intended for the use by the Parties and the Commissioner of the Tennessee Department of Health in preparing, filing and evaluating a COPA application and should not be used for any other purpose. This letter is based on the performance of the procedures described herein, and is limited to assessing whether the Plan of Separation (and other related documents as noted) can be operationally implemented without undue disruption to essential health services provided by the Parties.

Consistent with the current Tennessee COPA Application guidelines, this letter is based on a one-year time horizon. Our understanding is that one year following the combination, the Plan of Separation and this letter would need to be updated.

FTI does not give, and this letter does not constitute, legal advice. This letter is current as of its date, and FTI has no duty to update it. Among other matters, later changes in market conditions may affect the views expressed in this letter.

Sincerely,

FTI Consulting

FTI Consulting, Inc.

March 16, 2016

Allison Thigpen, MPH
Health System Improvement Coordinator
Division of Health Planning
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Re: Tennessee Department of Health's Request for an Addendum to the Application for a Certificate of Public Advantage

Dear Ms. Thigpen:

The following information is being provided in response to your letter dated February 29, 2016, relating to the Department of Health's request for an addendum to the application for issuance of a Certificate of Public Advantage ("COPA"). Specifically, we wish to address the Department's objectives and positions raised in your January 15, 2016, written in response to the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report" and identify where each objective/position is addressed in the COPA Application submitted on February 16, 2016. Each objective/position posed in your January 15th letter is set forth in its entirety in the attached Addendum together with the location in the Application where that objective/position is addressed. We have also provided an explanation about how the Application section responds to the Department's observations and positions where appropriate.

Additionally, we have included information about the recent announcement that Wellmont's Chief Financial Officer, Alice Pope, will be joining HonorHealth, addressed a technical correction in Section 6 of the Application and accompanying Exhibits, and provided full copies of Exhibits 11.4 - Attachment D and 11.4 - Attachment E.

We appreciate the opportunity to provide the Department with additional information that we hope will be helpful in reviewing the COPA Application. We would be happy to discuss any of this information or any questions that you, or your colleagues, may have.

Sincerely,

Mountain States Health Alliance
President &
Chief Executive Officer

Alan Levine

Wellmont Health System
President &
Chief Executive Officer

Bart Hove

Enclosure

CC: Valerie Nagoshiner
Malaka Watson
Jeff Ockerman

ADDENDUM #1 TO THE

APPLICATION

CERTIFICATE OF PUBLIC ADVANTAGE

STATE OF TENNESSEE

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: March 16, 2016

MARCH, 2016

Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States") (collectively referred to as the "Applicants") submitted an application (the "Application") to the Tennessee Department of Health on February 16, 2016 for issuance of a Certificate of Public Advantage ("COPA").

The Tennessee Department of Health (the "Department") has requested that the Applicants provide an addendum to the Application to address the Department's objectives and positions raised in the Department's January 15, 2016 letter, which was written in response to the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report."

Each objective/position posed in the Department's January 15th letter is set forth in its entirety below, together with the location in the Application where that objective/position is addressed. The Applicants have also provided an explanation about how that particular section (or sections) responds to the Department's observations and positions where appropriate (Section 1 below).

Additionally, the Applicants wish to formally notify the Department of Alice Pope's planned departure from Wellmont Health System (Section 2 below), addressed a technical correction in Section 6 of the Application and accompanying Exhibits (Section 3 below), and provided full copies of Exhibits 11.4 - Attachment D and 11.4 - Attachment E (Section 4 below).

SECTION 1: RESPONSE TO THE DEPARTMENT'S JANUARY 15, 2016 LETTER

Observation #1 - Geographic Service Area

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

Department Position:

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

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

Applicants' Response:

As the Department is aware, "geographic service area" is not defined in either the Tennessee COPA statute[24] or regulations.[25] A healthcare geographic service area may be defined in different ways, including by patient origin data, location of services, geographic features, political boundaries, population, and/or health resources. Since the Tennessee COPA statute and regulations do not define "geographic service area," the Applicants looked to the regulatory language for guidance. Tennessee Rules section 1200-38-01-.02(2)(a)(7) states:

> If the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the Application, a description of how and why the proposed geographic service area differs and why changes are proposed; [*emphasis added*]

For purposes of completing the COPA Application, the Applicants have interpreted the "proposed geographic service area" to mean the geographic area where the Applicants propose to conduct business as the New Health System.

The Applicants have historically served *patients* from a twenty-nine county area, which includes counties in Tennessee, Virginia, Kentucky, and North Carolina. While the Applicants serve patients from twenty-nine counties in Tennessee, Virginia, North Carolina, and Kentucky, Wellmont and Mountain States only have facilities and locations in Tennessee and Virginia. All of the Wellmont and Mountain States physical facilities and provider locations are located in Tennessee or Virginia and are subject to state regulations only in these two states. To the extent the Applicants draw some patients from adjacent North Carolina and Kentucky counties, these patients are served at the Applicants' facilities and provider locations in Tennessee and Virginia.

Section 5 of the Application provides a detailed description of the proposed geographic service area, not limited to the boundaries of the State of Tennessee. While the Applicants recognize that "geographic service area" may be defined in different ways, the Applicants have defined the "proposed geographic service area" in the COPA Application as the twenty-one counties in Tennessee and Virginia where the Applicants propose to conduct business as the New Health System. This twenty-one county area is inclusive of the Tennessee and Virginia counties in which the Applicants have locations and facilities and serve residents, and all locations and providers that will be under the control of the Applicants and subject to any regulation under the COPA or Cooperative Agreement. This 21-county area is inclusive of the vast majority of the population served by the Applicants, whether commercial, Medicare, Medicaid, or uninsured.

[24] Tennessee Code Section 68-11-1301 et seq.
[25] Tenn. Comp. R. & Regs 1200-38-01-.01 et seq.

Since Wellmont and Mountain States have only operated facilities in Tennessee and Virginia over the five years preceding the application, the proposed geographic service area for the COPA Application does not differ from the service areas where the Applicants have conducted business over the five years preceding the Application.

The Department correctly notes that the two Kentucky counties and six North Carolina counties are regularly included in business documents detailing the service area of Mountain States Health Alliance. As explained above, a healthcare "service area" may be defined in different ways. Both Wellmont and Mountain States have served *patients* from a twenty-nine county area that includes counties in Tennessee, Virginia, Kentucky, and North Carolina. However, Wellmont and Mountain States only have facilities in Tennessee and Virginia. As shown in the tables below, which is based on the same discharge data used in the Application and published by Tennessee and Virginia, patients from the six North Carolina counties identified in the 29-county area account for one half of one percent (0.5%) of the combined patient discharges. Patients from the two Kentucky counties identified in the 29-county area account for less than one half of one percent (0.4%) of the combined patient discharges. Ninety-eight percent (98%) of the combined patient discharges come from the proposed geographic service area - the 21 counties in Tennessee and Virginia.

	With MDC 19 and 20					
Patient County	MSHA	WHS	Combined	MSHA %	WHS %	Combined %
Total	59,594	35,810	95,404	100.0%	100.0%	100.0%
Proposed 21 County Geographic Service Area*	58,441	35,075	93,516	98.1%	97.9%	98.0%
Extended Service Area - NC**	456	35	491	0.8%	0.1%	0.5%
Extended Service Area - KY***	129	267	396	0.2%	0.7%	0.4%
All Other Counties	568	433	1,001	1.0%	1.2%	1.0%

	Without MDC 19 and 20					
Patient County	MSHA	WHS	Combined	MSHA %	WHS %	Combined %
Total	53,822	34,514	88,336	100.0%	100.0%	100.0%
Proposed 21 County Geographic Service Area*	52,835	33,828	86,663	98.2%	98.0%	98.1%
Extended Service Area - NC**	443	34	477	0.8%	0.1%	0.5%
Extended Service Area - KY***	123	263	386	0.2%	0.8%	0.4%
All Other Counties	421	389	810	0.8%	1.1%	0.9%

Notes:
Excludes DRG 795
Excludes Takoma Regional Hospital
*Includes the 21 counties and 2 independent cities across Tennessee and Virginia
**Includes the following six North Carolina counties: Ashe, Avery, Madison, Mitchell, Watauga, and Yancey
***Includes the following two Kentucky Counties: Harlan and Letcher

For the reasons stated above, the Applicants believe it is appropriate to define the geographic service area for purposes of the COPA Application as the twenty-one counties in Tennessee and Virginia.

Observation #2 - Prevention Services for all Categories of Payers

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

Department Position:

It is the department's position that, for the application to be deemed complete, prevention services will need to be more specifically enumerated. Consistent with department rule, the Cooperative Agreement must detail the "[p]roposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements...."[26]

Applicants' Response:

In Sections 11.i and 11.j of the Application, the Applicants outline their commitments to improving community health through investment of not less than $75 million over ten years in science and evidence-based population health improvement. Specifically, on pages 86-88 of the Application, the Applicants address the use of cost savings to fund prevention services across all payer groups. The Applicants interpret "such as" in the regulations cited by the Department to indicate that the proposed use of cost savings may be used for these types of programs or other types of programs that are designed to achieve long-term population health improvements. The Applicants expect that low or no-cost services such as screening programs and disease management programs will be essential elements of the plan to achieve long-term population health improvements as outlined in the Application. Additionally, the Applicants believe that focusing these low or no-cost programs for specific populations will likely yield the greatest long-term population health improvements. For example, immunization programs for children are well-established and well-funded in the region. However, improvements could be made with respect to immunization programs for pneumonia, flu, and HPV by targeting specific populations to help achieve greater results. The Applicants intend to invest in population health improvement efforts that generate more focused and meaningful value-based spending in the region. The sections of the Application addressing this position are included below for reference:

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

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

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

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

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

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

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

The Parties believe that prevention services, such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services, are all essential ingredients in achieving population health improvements and maintaining a population's long-term health and wellness. Certain counties in the service area have achieved noteworthy performance in specific areas. For example, the Northeast region[27] ranks among the best in Tennessee in immunizations, and Sullivan County ranks well in mammograms. However, as a general rule, the health status of the service area population is in need of significant improvement. Targeted efforts to address immunizations and preventive screenings are expected to be explicitly derived from the MAPP community health improvement process outlined in this Application. The Parties intend to address chronic disease management as part of the "Helping Adults Live Well" strategy outlined in this Application. Specific plans regarding drug and alcohol abuse services are detailed in **Section 8.H** of this Application. It is anticipated that the Community Health Work Groups, the Advisory Groups appointed by the Commissioner, and the agreed-upon Health Index will reflect specific actions and strategies in connection with a broad range of prevention services, including immunizations, mammograms, chronic disease management and drug and alcohol abuse services. Further, the Parties believe there are significant opportunities to partner with all categories of payers to create effective systems of care for best practice preventative services and to extend those services to both economically and geographically underserved populations through effective collaboration with Federally Qualified Health Centers, charity care clinics, health departments and others. In addition, Mountain States operates drop-by Health Resources Centers which support chronic disease prevention and management in Kingsport and Johnson City and Wellmont owns and operates mobile health buses that are equipped to offer immunizations, cardiovascular and cancer screenings, mammograms, and physicals along with

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

health education and coaching resources to engage with populations for effective behavior change and the extension of disease management resources. Mobile strategies will allow reach into populations with both economic and geographic barriers and can be further supplanted by a host of health IT and telemedicine strategies which are envisioned to be developed as part of the long-range community health improvement plan. Both organizations operate nurse call centers which are able to engage with populations for the development of wellness and prevention coaching and disease management programming to help overcome geographic and social barriers.

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

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

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

Observation #3 - Equity

The explanation of how the New Health System will provide equitable health services with respect to maintaining quality and competition within the service area needs further explanation.[28] The department acknowledges the report includes a discussion of access to services in rural areas.

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

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

Department Position

Consistent with department rules, the application should include policies that specifically address Medicaid and Medicare populations and people without insurance.[29] Moreover, the population health improvement plan detailed in the application should cover all residents in the geographic service area.

Applicant's Response:

As noted in Section 11.g.iii.III of the COPA Application, Wellmont and Mountain States are the primary providers for Medicare and Medicaid in the region, and operate the primary system of access for children. Additionally, the primary location for inpatient mental health services for the uninsured and Medicaid population are housed within Mountain States. As part of the COPA Application, the Applicants provided the State with the current Charity Care and related policies of both Wellmont and Mountain States in the following exhibits:

Exhibit 8.4 - Attachment A	Mountain States' Charity Care Policy
Exhibit 8.4 - Attachment B	Mountain States' Credit and Collection Policy - Patient Accounts
Exhibit 8.4 - Attachment C	Mountain States' Collection Agency Process - Fiscal Services
Exhibit 8.4 - Attachment D	Mountain States' Code of Ethics and Business Conduct
Exhibit 8.5 - Attachment A	Wellmont's Patient Bill of Rights
Exhibit 8.5 - Attachment B	Wellmont's Charity Care Policy and Related Policies
Exhibit 8.5 - Attachment C	Wellmont Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy

As explained on pages 73-76 of the Application, the New Health System will continue to remain committed to these populations, a commitment neither system can make without the proposed merger. If the COPA is granted, the Applicants intend for the New Health System to adopt policies that are substantially similar to the existing policies of both Applicants and consistent with the IRS's final 501(r) rules. The New Health System is a shell entity at this point with no authority to implement charity care or other policies that would govern the operations of the merged enterprise. However, as evidence of the Applicant's commitment to implement similar policies if the COPA is granted, the Applicants have committed in the executed

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

Cooperative Agreement that the New Health System will adopt policies that are substantially similar to the existing policies of both Applicants.[30]

To further address the Department's interest in the New Health System's provision of equitable health services, the Applicants address each category of patients on pages 74-76 of the Application. This section is included below for reference:

> Medicare. Many of the "Helping Adults Live Well" strategies discussed in this Application will be designed specifically for the Medicare senior population and dual eligible population. Medicare hospital and physician pricing is determined by government regulation and is not a product of competition or the marketplace. As a result, the merger is not expected to impact the cost of care to Medicare beneficiaries, but access to and quality of services are expected to improve. Additionally, through care coordination models implemented as part of value based arrangements, it is expected that use rates will be favorably affected, and savings to the Medicare program will result. The many strategies contained within this Application, including implementation of a Common Clinical IT Platform, will be key factors in succeeding within the value-based Medicare environment.
>
> Medicaid. Many of the population health strategies detailed in this Application, such as child maternal health, will directly benefit the Medicaid population, and thus, the program. Also, the New Health System will seek innovative value-based models with the commercial payers that serve as intermediaries to the state Medicaid programs. Such models may include care management/shared savings, integrated mental health services and development of access points of care for the Medicaid and uninsured populations. It is widely known that simply having a Medicaid card does not equate to access. The intent of the New Health System is to ensure an organized care delivery model which optimizes the opportunity for access in the lowest cost, most appropriate setting. Importantly, these opportunities become more likely when the New Health System has the scale in terms of the number of lives it is managing. This should be an attractive feature for the states and to those payers acting as intermediaries with the states.
>
> Uninsured Population. As described in **Section 8.G** of this Application, both Parties currently provide significant amounts of charity care to the vulnerable populations in the Geographic Service Area and will continue to do so in the future. If the COPA is granted, the Parties intend that the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties. The uninsured

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

population will also be the target of several inter-related health strategies outlined in this Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the service area. The Parties intend to work with charitable clinics in the area to improve access for the uninsured population to patient-centered medical homes, federally qualified health centers, and other physician services. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

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

- Develop effective strategies to reduce the over-utilization and unnecessary utilization of services, particularly high-cost services such as emergency department care. This better-managed, more proactive approach will be developed in collaboration with a host of community-based resources and will be consistent with the CMS Accountable Health Communities model. Under this model, both traditional health care resources and societal resources are considered in tandem. Recognizing that factors such as transportation, educational attainment, food availability, housing, social support and other factors play a key role in health care access and outcomes, effective program development will include opportunities to help high-utilizers of care gain awareness of available resources, provide navigational access to those resources, and ensure systems of contact and collaboration exist and are effective.

- Develop with the State and community stakeholders Key Focus Areas for population health investment and intervention. These index categories will apply regardless of payer and the priorities for programming and intervention will be based on the communities where the need/impact will be greatest. The Parties intend to account for geographic gaps and disparities by aiming resources or strategies at specific populations, which will be outlined in the long-term community health improvement plan. Where payers have existing care management programs in place, the New Health System will work with payers to increase compliance for effective prevention and disease management programs. The Parties strongly believe that the New Health System must provide opportunities for prevention, navigation, and disease management, and must connect individuals, regardless of their coverage status, to community-based resources if the regional population health management initiative is to be successful.

Observation #4 - Health of the Region and Population Health Disparities

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

Department Position

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

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

Applicants' Response:

In Section 8.A of the Application, the Applicants address the significant health care challenges that face the population of the geographic service area. As outlined on page 30, a 2015 Tennessee Department of Health report, *Drive Your County to the Top Ten*,[31] found that:

- All Tennessee counties in the Geographic Service Area exceed the national average for smoking
- The state level obesity rate exceeds the national average, and several counties within the Geographic Service Area have obesity rates of more than thirty percent (30%).
- Three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for frequency of low birthweight births and
- Three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for teen pregnancy rates.

[31] "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available here: https://www.tn.gov/health/topic/specialreports

Table 8.1 on page 31 of the Application reports key statistics on the population in the counties within the Geographic Service Area, including metrics for obesity, smoking, childhood poverty, and death rates due to drug poisoning. Full County Health Rankings for all Tennessee and Virginia Counties and Independent Cities located in the Geographic Service Area are attached to the Application as Exhibit 8.1A and 8.1B. Table 8.1 is provided below for reference.

Table 8.1 from the COPA Application

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

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

The Applicants specifically addressed the health priorities of the State in the discussion of the "Big Three Plus One" health issues (physical inactivity, obesity, tobacco abuse and substance abuse) on pages 31-35. As noted in the Application, these four health issues are particularly significant challenges for the Geographic Service Area and are associated with other health challenges and conditions that are responsible for higher health care utilization.

The Applicants' discussion of the "Big Three Plus One" issues from the Application are included below for reference:

> Physical Inactivity & Obesity
>
> Obesity and physical inactivity are mutually reinforcing public health concerns. Tennessee's state level obesity rate exceeds the national average. While most of the Tennessee counties in the 21-county geographic service area have obesity rates lower than the state average, Hawkins and Sullivan Counties are exceptions at 35% and 33% respectively. All of the Tennessee counties in the geographic service area exceed the state average for physical inactivity (30%). Most notably, Unicoi County has a physical inactivity rate of 37.0% and Hancock County has a physical inactivity rate of 39.4%. Measures for Virginia counties in the service area reflect challenges as well.
>
> Tobacco Abuse
>
> The "2015 Drive Your County to the Top Ten" report[32] published by the Tennessee Department of Health Division of Policy, Planning, and Assessment State Department of Health demonstrates that all of the Tennessee counties in the 21-county geographic service area exceed the national average for smoking, and seven of the ten Tennessee counties exceed the state average for smoking. In particular, Hancock County and Carter County are at the high end of the range with smoking rates that exceed 30%.
>
> Substance Abuse
>
> Substance abuse is a key priority of the Tennessee Department of Health and a significant concern in this region. Of the ten Tennessee counties in the geographic service area, nine exceed the state average in the number of deaths due to drug poisoning per 100,000 population. Of particular note is Hancock County, which has the highest drug poisoning mortality rate in the state. Addressing substance abuse is one of the highest priorities of the New Health System, with efforts to address the specific needs of this population as well as improve access to, and coordination of care at, healthcare facilities for substance abuse patients.

[32] "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available here: https://www.tn.gov/health/topic/specialreports

Table 8.2 reports key statistics on the population in the counties in the 21-county area for the "Big Three +1" health issues, including metrics for physical inactivity, obesity, tobacco use, and substance abuse. Red shading indicates that the County scores worse than the state average for that particular metric.

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

* Red shading indicates that a County's score exceeds the state average.

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

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

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

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

> The Parties share the State's concern about these four significant health issues and are aware of the acute challenges present in this region. The Parties intend for these four issues to be key areas of focus within the scope of the current Community Input Work Groups, as well as included in the Advisory Groups that will work to define the health index for the geographic service area.

The Applicants acknowledge that the New Health System will be responsible for population health in the region for an indefinite period of time. As a result, the New Health System has proposed a plan for development of the Index of Public Advantage and Community Health Improvement that includes input from community stakeholders and the State as outlined in Section 11.j of the Application. Additionally, the Applicants have set forth a proposal for development of this Index in Table 11.7, which identifies the proposed five Key Focus Areas in which the New Health System is committed to investing in community health improvement and which the Applicants propose be included in the Commitment to Community Health Annual Report. Within each Key Focus Area, the Applicants have identified specific Health Concerns that pose an important challenge and priority for health in this region that are aligned with health challenges and priorities identified by the states. The Applicants have also identified a common national measure and a reliable source of data used to track each county's status relative to this Health Concern. These measures provide for comparison with other areas in the states or nationally. The Applicants have proposed a representative investment, intervention or performance improvement that could be implemented by the New Health System to address a specific Health Concern. It is proposed that these be identified in partnership with the State and with regional stakeholders over time as part of the MAPP Community Health Improvement Process described earlier and that several investments, interventions or performance improvements are likely to be necessary to address each concern across the Geographic Service Area. The relevant Accountability Mechanism the Applicants believe reflects the New Health System's performance related to the investment, intervention, or performance improvement is also identified for each Health Concern. The Applicants have proposed a representative progress measure that could be used to measure progress in the Geographic Service Area for this health concern, and finally, the Applicants have identified County level disparities for each Health Concern as measured by the counties in the Geographic Service Area in Tennessee and Virginia that have the lowest/poorest measure. This recognizes the states' concerns that specific areas may warrant particular attention or intervention.

The Applicants seek to engage the COPA Index Advisory Group and the State in the final determination of the measures to be included in the Health Index. The Applicants expect to be held accountable for the commitments outlined in the Application and believe it is the goal of all those involved that the population health of the Geographic Service Area will improve with the New Health System's commitment of substantial resources and improved coordination of new and existing health programs.

Observation #5 - Duplication of Services

As noted in the report, MSHA and WHS currently have "expensive duplications of costs" and plan to reduce duplications post-merger through delivery model integration and "job displacement."[37] Limited detail of these plans is provided.

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

Department Position:

Pursuant to department rule, the application must include "economic metrics that detail anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement."[38]

To ascertain how efficiencies in operating costs and shared services could potentially impact population health and health care, the department needs additional detail to evaluate the potential benefits and disadvantages of these plans to achieve these cost savings. Specifically, the department will require a good faith estimate of the number of full-time equivalent positions estimated to be eliminated each year, or if none, other plans to achieve stated efficiencies.

Applicants' Response

Section 11.i of the Application details the anticipated efficiencies in operating costs and shared services the Applicants expect to gain through the Cooperative Agreement. As noted on pages 81-82 of the Application, funding the population health, access to care, enhanced health services, and other commitments described in the Application would be impossible without the efficiencies and savings created by the merger. The New Health System, by aligning Wellmont and Mountain State's individual efforts in key service areas, will be able to drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services. The Applicants commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to specifically perform an economies and efficiencies analysis regarding the proposed savings and efficiencies to address this question in the Application. As detailed on pages 82-84 of the Application, the economies

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

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

analysis was divided into three major segments. Segment One was the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two was the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three was the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies"). The findings of the FTI Consulting Report are addressed in the Application on pages 82-83 and copied below for reference:

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

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

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

2. Labor Efficiencies. The workforce is the lifeblood of a health care organization, and the competition for the labor force will remain intense, both locally and regionally. As stated in **Section 6** herein, the majority of outpatient services will not be controlled by the New Health System, and other very significant inpatient providers are located nearby. Thus, the New Health System will remain competitive as it relates to salary and benefit offerings, and will be committed to the ongoing development of its workforce. As discussed in **Section 11.f**, the Parties are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions

within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Parties have identified potential savings from the merger in labor expenses totaling approximately $25 million annually. These savings could extend across a variety of departments and areas:

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

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

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

3. Clinical Efficiencies. The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most

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

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

The Applicants wish to specifically address the Department's questions about workforce. As detailed on page 83, the Applicants are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Applicants do not anticipate any merger-related reductions in force that would trigger federal or state notification obligations. At this time, the Applicants believe that the workforce adjustments can primarily be handled through reassignment of duties and normal attrition.

Additionally, in Section 11.f, beginning on page 67 of the Application, the Applicants address the State's questions about the impact of the merger on the service area's health care industry workforce. The Applicants' expect to achieve substantial efficiencies and reduce unnecessary duplication of services, but it is not anticipated that the overall clinical workforce in the region will decrease significantly. Demand for health professionals is generally driven by patient volumes and varies across the market from time to time. The Applicants recognize that health care workers are in great demand in this particular region, and retaining and developing excellent health professionals in the region will be of utmost importance to the New Health System to ensure the highest clinical quality.

Observation #6 - Reinvestment of Cost Savings

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

Department Position

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

Applicants' Response:

The Applicants addressed this objective in Section 11.i of the Application in the discussion of the anticipated efficiencies in operative costs and shared services the Applicants expect to gain through the Cooperative Agreement. Specifically, the Applicants would like to draw your attention to the following:

At the end of "Non-Labor Efficiencies" section on page 82, the Applicants state:

> The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

At the end of the "Labor Efficiencies" section on pages 83-84, the Applicants state:

> These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the

> community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

At the end of the "Clinical Efficiencies" section on page 84, the Applicants state:

> The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.
>
> The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

SECTION 2: DEPARTURE OF ALICE POPE, WELLMONT'S CHIEF FINANCIAL OFFICER

On March 8, 2016, Wellmont Health System announced that Alice Pope, the system's executive vice president and chief financial officer, will become the new chief financial officer for HonorHealth in Scottsdale, Arizona. Pope will continue serving in her Wellmont leadership position, which she has held for 3 ½ years, for the next 60 days and will assist in a smooth transition. She has worked for Wellmont for 16 years, steadily advancing to positions of increasing responsibility. The timing of Pope's announcement was, in part, to allow strategic decisions to be made for Wellmont and for the new health system that would result from the proposed merger of Wellmont and Mountain States Health Alliance if the Application is approved.

In the term sheet and applications for a Certificate of Public Advantage in Tennessee and cooperative agreement in Virginia, Pope was designated to serve as the proposed new health

system's chief financial officer. The chief financial officer position for the proposed new health system will be evaluated by both Applicants given Pope's departure and the Applicants will notify the Department of any decisions by the Applicants that may affect the executive leadership structure of the New Health System or the COPA Application. The change is not expected to impact the proposed merger itself.

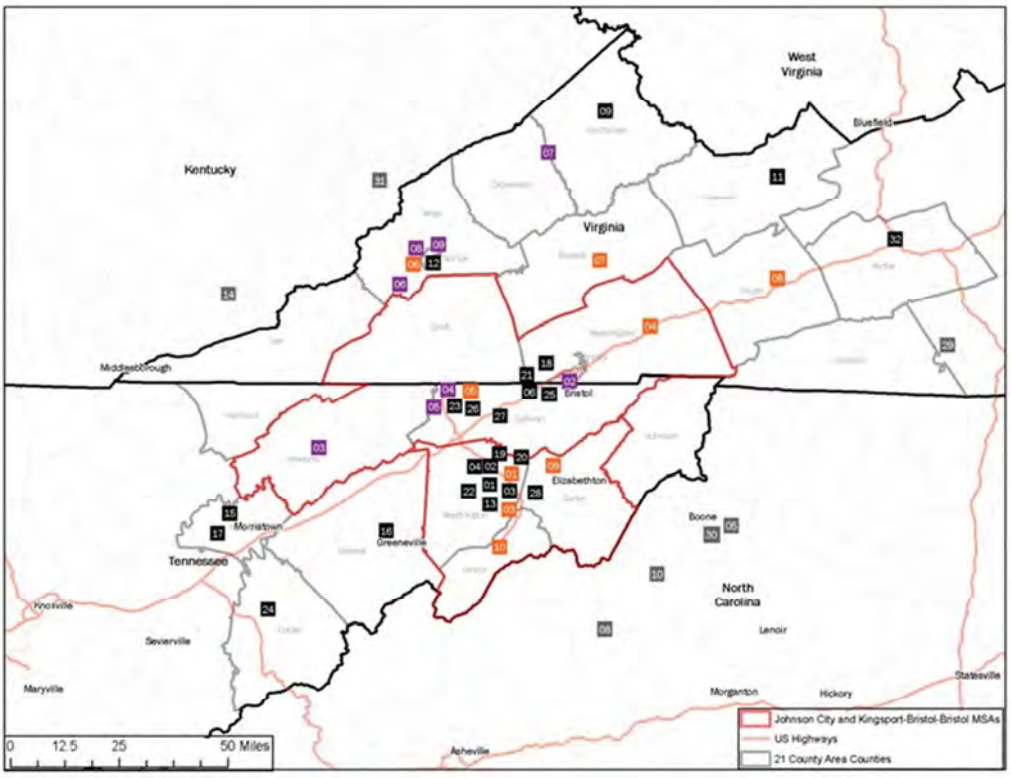
SECTION 3: TECHNICAL CORRECTION TO SECTION 6 OF THE COPA APPLICATION AND ACCOMPANYING EXHIBITS

Section 6 of the Application and Exhibit 6.1D list the Ambulatory Surgical Center Locations and Counts, by System. Among the Ambulatory Surgical Center Locations listed in the Application is the State of Franklin OB/GYN, which is listed as performing surgery in an ASC setting. It has come to the Applicants' attention that the State of Franklin OB/GYN performs in-office surgical procedures but does not have an Ambulatory Surgical Center. To correct this oversight, the Applicants wish to remove the State of Franklin OB/GYN from the list of ASCs. This change will affect the following four sections of the Application:

1) Application Section 6 - pages 25-26

- Delete the following:

> Wellmont and Mountain States each have ambulatory surgery centers ("ASCs")[24] in the area, but fifty-seven percent (57%) are competing facilities. The locations of all area ASCs are shown in Figure 6.3 below. Exhibit 6.1D lists all ASCs serving the Geographic Service Area.[25]
>
> Figure 6.3 – Map of Location of Ambulatory Surgical Centers[26]



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

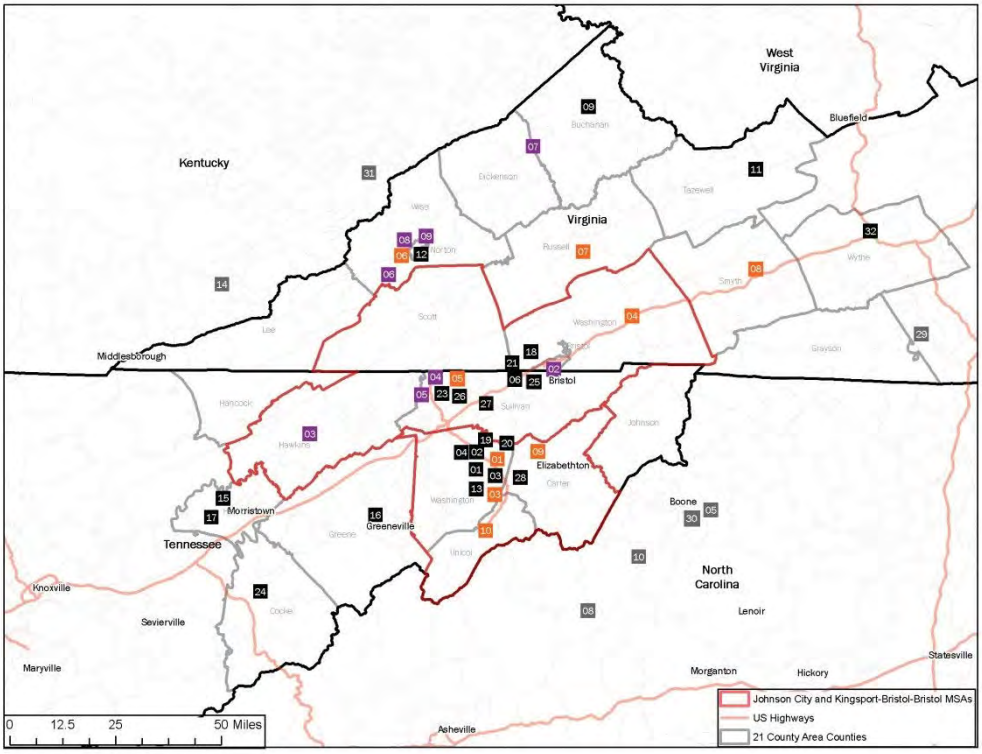
[25] The outpatient facilities listed in Exhibit 6.1D include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

[26] An enlarged version of the map and the legend are attached as Exhibit 6.1D.

- Replace it with:

Wellmont and Mountain States each offer outpatient surgery services[24] in the area, but fifty-five percent (55%) of the outpatient surgical facilities in the area are operated by competitors of Wellmont and Mountain States. The locations of all area outpatient surgical facilities are shown in **Figure 6.3** below. **Table 11.5** and **Exhibit 6.1A** break out the count and share for each category of outpatient surgical facilities while **Exhibit 6.1D** lists all outpatient surgical facilities serving the Geographic Service Area.[25]

Figure 6.3 – Map of Location of Outpatient Surgical Facilities[26]



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

[25] The outpatient surgical facilities listed in Exhibit 6.1D include the outpatient surgical facilities located in the Geographic Service Area and serving the Geographic Service Area.

[26] An enlarged version of the map and the legend are attached as Exhibit 6.1D.

2) Application Table 11.5

- Delete the following:

Table 11.5 - Shares of Outpatient Facilities by System

Service Type	WHS & MSHS 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.

- Replace it with:

TABLE 11.5 - SHARES OF OUTPATIENT FACILITIES BY SYSTEM

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

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

3) Application Exhibit 6.1 - Attachment A

- Delete the following:

A. All Outpatient Facilities

Service Type	WHS & MSHS 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**

- Replace it with:

A. All Outpatient Facilities

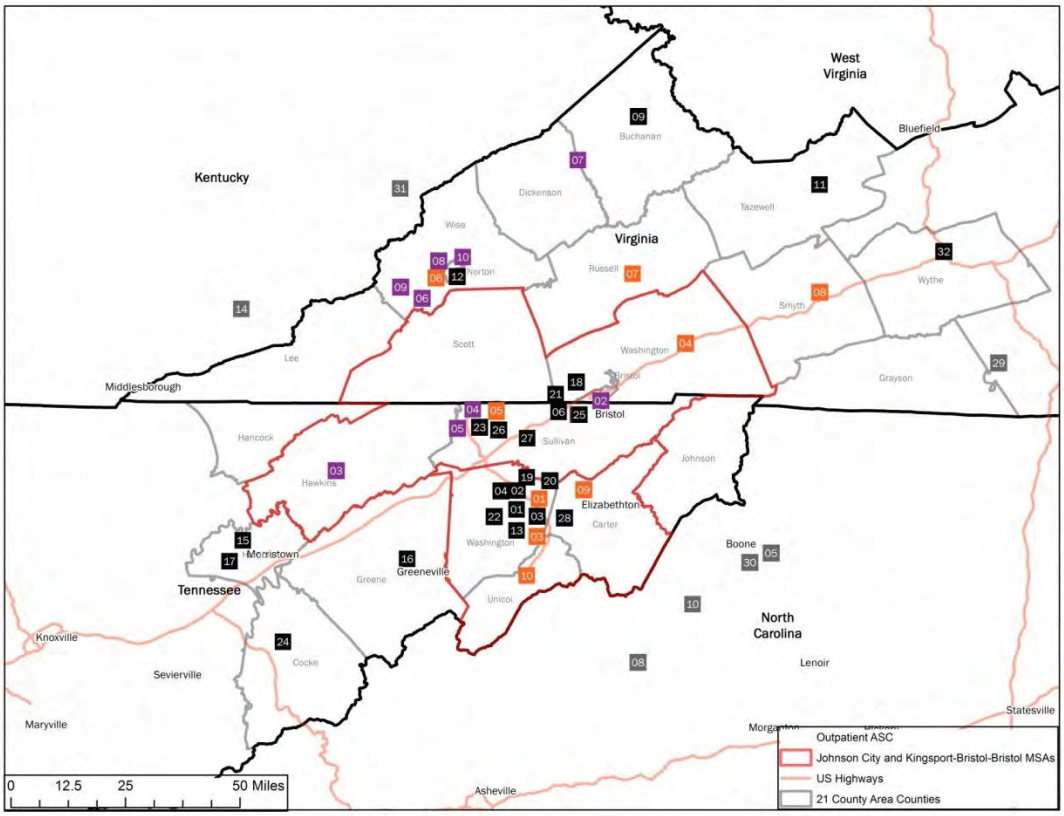
Service Type	WHS & MSHS Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	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	60.0%	2	0	3	4	6	15
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

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

4) Application Exhibit 6.1 - Attachment D

- Delete the following:

D. Ambulatory Surgical Centers



Ambulatory Surgical Centers Outpatient Facilities

Wellmont

01	Bristol Regional Medical Center
02	Bristol Surgery Center
03	Hawkins County Memorial Hospital
04	Holston Valley Medical Center
05	Holston Valley Sugery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital *(Independent)**
09	Wellmont Loesome Pine Hospital
10	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.

** Non-Managed Joint Venture

Ambulatory Surgical Center Locations and Counts, by System

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

Ambulatory Surgical Center Locations and Counts, by System

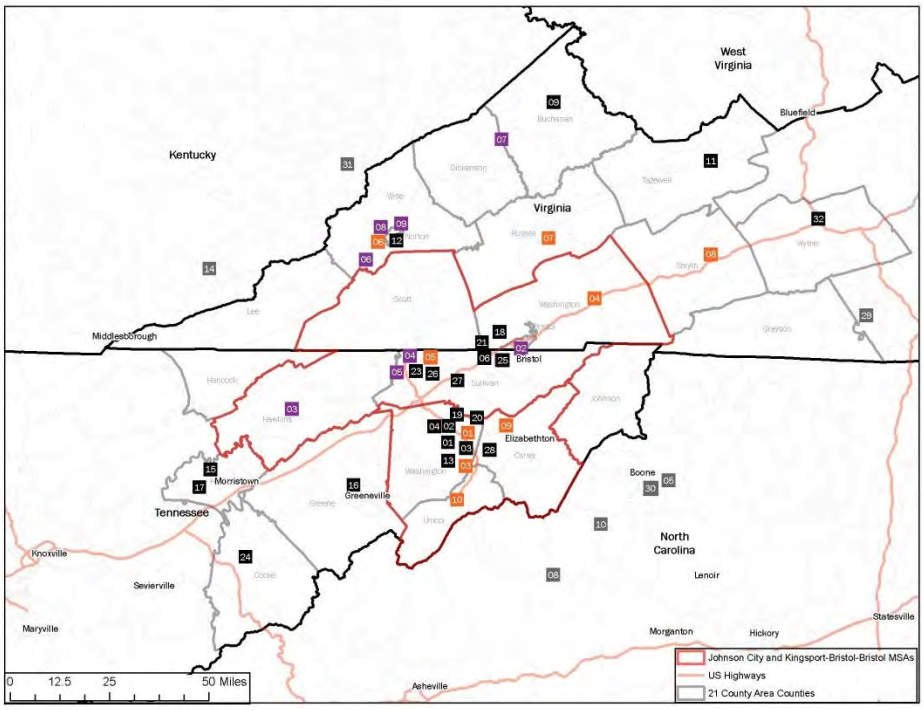
System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Non-Managed Joint Venture	TriCities Laser Center	Washington	TN	X		
Non-Managed Joint Venture	**Total**			**4**	**0**	**0**
All Other	Appalachian Gastroenterology	Watauga	NC		X	
All Other	Ashe Memorial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

Ambulatory Surgical Center Locations and Counts, by System

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

- Replace it with:

D. Outpatient Surgical Facilities*



* Outpatient Surgical Facilities include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities. These facilities are included in the map and table.

Outpatient SurgicalFacilities

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
23	Sullivan Digestive Center
24	Tennova Healthcare - Newport Medical Center
25	The Endoscopy Center of Bristol
26	The Regional Eye Surgery Center
27	Tri Cities Gastroenterology
28	Tri-Cities Outpatient Surgery, LLC
29	Twin County Regional Hospital
30	Watauga Medical Center
31	Whitesburg ARH Hospital
32	Wythe County Community Hospital

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

** Managed Joint Venture

*** Non-Managed Joint Venture

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Total	**Total**			**15**	**31**	**30**
Wellmont	Bristol Regional Medical Center	Sullivan	TN		X	X
Wellmont	Bristol Surgery Center	Sullivan	TN	X		
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN		X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN		X	X
Wellmont	Holston Valley Surgery Center, LLC	Sullivan	TN	X		
Wellmont	Lonesome Pine Hospital	Wise	VA		X	X
Wellmont	Sapling Grove ASC	Sullivan	TN	X		
Wellmont	Wellmont Mountain View Regional Medical	Wise	VA		X	X
Wellmont	**Total**			**3**	**5**	**5**
Mountain States	Franklin Woods Community Hospital	Washington	TN		X	X
Mountain States	Indian Path Medical Center	Sullivan	TN		X	X
Mountain States	Johnson City Medical Center	Washington	TN		X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X	X
Mountain States	Kingsport Ambulatory Surgery Center**	Sullivan	TN	X		
Mountain States	Norton Community Hospital	Wise	VA		X	X
Mountain States	Russell County Medical Center	Russell	VA		X	X
Mountain States	Smyth County Community Hospital	Smyth	VA		X	X
Mountain States	Sycamore Shoals Hospital	Carter	TN		X	X
Mountain States	Unicoi County Community Hospital	Unicoi	TN		X	X
Mountain States	**Total**			**2**	**9**	**9**
Non-Managed Joint Venture	East Tennessee Ambulatory Surgery Center, LLC	Washington	TN	X		
Non-Managed Joint Venture	Johnson City Eye Surgery Center	Washington	TN	X		
Non-Managed Joint Venture	Mountain Empire Surgery Center, LP	Washington	TN	X		

Outpatient Surgical Facility Types, Locations and Counts, by System

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

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
All Other	Tri-Cities Outpatient Surgery, LLC	Washington	TN	X		
All Other	Twin County Regional Hospital	Grayson	VA			X
All Other	Watauga Medical Center	Watauga	NC		X	X
All Other	Whitesburg ARH Hospital	Letcher	KY		X	X
All Other	Wythe County Community Hospital	Wythe	VA			X
All Other	**Total**			**6**	**17**	**16**

** Kingsport Ambulatory Surgery Center is a Managed Joint Venture.

SECTION 4: EXHIBITS 11.4 - ATTACHMENT D AND 11.4 - ATTACHMENT E

Certain exhibits were withheld from the Application because they contained competitively sensitive or confidential information of the Applicants. Among the exhibits withheld were Exhibit 11.4 - Attachment D - Mountain States Covenant Compliance Certificates for the Last Five Years and Exhibit 11.4 - Attachment E - Mountain States Officer's Certificate Accompanying the Independent Auditor's Report for FY10 to FY14.

After further discussions with counsel, Mountain States has determined that these two exhibits (11.4 - Attachment D and 11.4 - Attachment E) should be filed publicly with the Department. The Applicants have attached these exhibits to this Addendum #1 for review by the Department.

The Applicants support the Department's commitment to transparency in reviewing the Application and will continue to work with counsel, the Department, and the Tennessee Attorney General's office to make all information required for the Application available to the Department while respecting federal antitrust laws.

Exhibit 11.4

Attachment D

Mountain States Covenant Compliance Certificates

Johnston Memorial Hospital
Covenant Compliance Certificate

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

Status as of: 3/31/2014

Debt Service Coverage

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

Debt to Capital

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

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

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

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

Mountain States Health Alliance

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

Johnston Memorial Hospital
Covenant Compliance Certificate

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

Status as of: 3/31/2015

Debt Service Coverage

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

Debt to Capital

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

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

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 6/30/2013

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Vice President/Corporate CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

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

Status as of: 6/30/2014

Debt Service Coverage

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

Debt to Capital

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

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

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

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

Mountain States Health Alliance

By: Lynn Krulak

Print Name: Lynn Krulak

Title: Senior Vice President & CFO

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 6/30/2015

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 6/30/2015

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

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

MONTH OF JUNE						TWELVE MONTHS YEAR TO DATE				
Actual	Budget	Bud Var	Prior Yr	PY Var		Actual	Budget	Bud Var	Prior Yr	PY Var
					Operating Statistics (excl Long-Term Care)					
81	71	14.8%	71	14.3%	Average Daily Census	81	69	17.5%	64	26.1%
70.2%	61.1%	14.8%	61.4%	14.3%	Occupancy Percent	70.1%	59.6%	17.5%	55.6%	26.1%
2,444	2,128	14.8%	2,138	14.3%	Patient Days	29,660	25,232	17.5%	23,524	26.1%
739	639	15.6%	649	13.9%	Admissions	9,009	7,646	17.8%	7,109	26.7%
339	259	30.9%	299	13.4%	Observation Visits	3,816	3,717	2.7%	4,130	-7.6%
247	181	36.5%	201	22.9%	Non OB Observation Visits	2,816	2,625	7.3%	2,993	-5.9%
25.1%	22.1%	13.5%	23.6%	5.9%	Non OB Observation Visits % of Non OB Observation Visits & Acute Admissions	23.8%	25.6%	-6.8%	29.6%	-19.6%
7.9%	5.4%	46.3%	8.2%	-3.5%	Non OB Observation % of Occupancy	6.9%	6.5%	6.1%	10.4%	-34.4%
6,397	5,435	17.7%	5,966	7.2%	Adjusted Patient Days	75,521	66,126	14.2%	70,039	7.8%
1,934	1,632	18.5%	1,811	6.8%	Adjusted Admissions	22,939	20,038	14.5%	21,166	8.4%
20,286	17,993	12.7%	20,610	-1.6%	Outpatient Visits	229,145	221,374	3.5%	249,494	-8.2%
3,484	2,989	16.6%	3,275	6.4%	ED Visits	41,308	36,299	13.8%	39,161	5.5%
60	129	-53.5%	60	0.0%	Home Health Episodes	646	1,543	-58.1%	811	-20.3%
114	121	-5.8%	112	1.8%	IP Surgery Cases	1,468	1,443	1.7%	1,296	13.3%
476	460	3.5%	416	14.4%	OP Surgery Cases	5,265	5,655	-6.9%	5,560	-5.3%
					Revenue By Source					
36.1%	39.6%	-3.5%	36.7%	-0.6%	Medicare	38.1%	39.6%	-1.4%	39.5%	-1.3%
17.9%	13.3%	4.6%	12.8%	5.1%	Managed Medicare	15.5%	13.3%	2.2%	13.3%	2.2%
12.1%	13.9%	-1.8%	13.4%	-1.3%	Medicaid	12.2%	13.9%	-1.7%	13.6%	-1.4%
0.3%	0.3%	0.0%	0.4%	-0.1%	TennCare	0.4%	0.3%	0.1%	0.3%	0.0%
16.8%	16.3%	0.5%	18.3%	-1.5%	Blue Cross	17.1%	16.3%	0.8%	16.6%	0.5%
2.4%	1.7%	0.7%	1.7%	0.7%	United - River Valley	1.7%	1.7%	0.0%	1.7%	0.0%
6.7%	5.4%	1.3%	6.2%	0.4%	Managed Care / Commercial	5.6%	5.4%	0.3%	5.4%	0.2%
6.0%	7.8%	-1.9%	8.4%	-2.5%	Charity / Self Pay	7.5%	7.8%	-0.3%	8.0%	-0.4%
1.8%	1.7%	0.0%	2.1%	-0.3%	Other Patient Revenue	1.9%	1.7%	0.2%	1.7%	0.2%
100.0%	100.0%		100.0%		Total Gross Patient Revenue	100.0%	100.0%		100.0%	
$9,995	$10,453	-4.4%	$8,694	15.0%	IP Revenue per Patient Day	$9,368	$10,495	-10.7%	$8,794	6.5%
$1,948	$1,921	1.4%	$1,615	20.6%	OP Revenue per Outpatient Visit	$1,875	$1,939	-3.3%	$1,639	14.4%
$2,348	$2,033	15.5%	$2,237	5.0%	Operating Revenue per Adjusted Patient Day	$2,033	$2,035	-0.1%	$1,874	8.5%
$1,774	$1,886	5.9%	$1,590	-11.6%	Operating Expense per Adjusted Patient Day	$1,724	$1,883	8.4%	$1,838	6.2%
$7,766	$6,769	14.7%	$7,370	5.4%	Operating Revenue per Adjusted Admission	$6,692	$6,716	-0.4%	$6,201	7.9%
$5,868	$6,281	6.6%	$5,239	-12.0%	Operating Expense per Adjusted Admission	$5,676	$6,212	8.6%	$6,083	6.7%
21.8%	19.1%	14.1%	20.6%	6.1%	Net Revenue % of Gross Revenue	21.2%	19.1%	11.2%	20.5%	3.7%
$7,221	$6,666	8.3%	$5,898	22.5%	Net Revenue per Adjusted Admission	$6,544	$6,609	-1.0%	$5,956	9.9%
					Labor Management (excl Long-Term Care)					
902	815	-10.7%	794	-13.7%	Employed Full Time Equivalents	824	805	-2.3%	791	-4.2%
14	2	-453.7%	13	-8.7%	Contract Full Time Equivalents	10	4	-133.1%	5	-94.5%
916	818	-12.0%	806	-13.6%	Total Full Time Equivalents	834	810	-3.0%	796	-4.8%
4.30	4.51	4.8%	4.05	-6.0%	FTEs per Adjusted Occupied Bed (Incl Cont Lbr)	4.03	4.47	9.8%	4.15	2.8%
81.0	85.6	5.5%	76.1	-6.4%	Man Hours per Adjusted Admission (incl Cont Lbr)	75.6	84.0	10.0%	78.2	3.3%
$21.10	$21.68	2.6%	$21.40	1.4%	Average Hourly Rate (excl Cont Lbr)	$22.01	$21.56	-2.1%	$21.52	-2.3%
$43,894	$45,084	2.6%	$44,502	1.4%	Salary Expense per FTE (excl Cont Lbr)	$45,780	$44,851	-2.1%	$44,762	-2.3%
$2,481	$2,548	2.6%	$2,070	-19.9%	Labor Exp (excl Phys) per Adjusted Admission	$2,245	$2,408	6.8%	$2,210	-1.6%
37.4%	42.5%	12.0%	44.7%	16.2%	Labor Exp % of Net Revenue	39.7%	42.7%	7.2%	47.1%	15.9%
					Patient Resource Management					
3.60	3.66	1.6%	3.51	-2.5%	Overall Medicare Average Length of Stay	3.58	3.62	1.1%	3.63	1.4%
3.31	3.33	0.7%	3.29	-0.4%	Overall Average Length of Stay	3.29	3.30	0.2%	3.31	0.5%
3.60	3.65	1.5%	3.55	-1.3%	Acute Medicare Average Length of Stay	3.58	3.62	1.1%	3.63	1.4%
2.49	2.85	12.7%	2.57	3.1%	Acute Medicare Average Length of Stay - Acuity Adjusted	2.57	2.83	9.0%	2.81	8.6%
3.31	3.33	0.7%	3.29	-0.4%	Acute Overall Average Length of Stay	3.29	3.30	0.2%	3.31	0.5%
2.42	2.80	13.5%	2.55	5.1%	Acute Overall Average Length of Stay - Acuity Adjusted	2.49	2.77	10.3%	2.76	10.0%
1.11	1.04	-7.2%	1.42	21.5%	Observation Average Length of Stay	1.03	1.04	1.1%	1.48	30.3%
1.44	1.28	12.8%	1.38	4.5%	Overall Medicare Case Mix Index	1.39	1.28	8.6%	1.29	7.9%
1.34	1.11	20.4%	1.22	9.6%	Overall Case Mix Index	1.30	1.11	16.7%	1.12	15.6%
1.44	1.28	12.8%	1.38	4.5%	Acute Medicare Case Mix Index	1.39	1.28	8.6%	1.29	7.9%
1.37	1.19	14.8%	1.29	5.8%	Acute Overall Case Mix Index	1.32	1.19	11.2%	1.20	10.6%
14.0%	15.7%	10.9%	19.5%	28.3%	Supply Expense % of Net Revenue	14.8%	15.6%	4.9%	15.5%	4.4%
$1,009	$1,046	3.5%	$1,149	12.2%	Supply Expense per Adjusted Admission	$971	$1,031	5.8%	$924	-5.0%

Johnston Memorial Consolidated

Statement of Revenue and Expense

For the Period Ended June 30, 2015

MONTH OF JUNE						TWELVE MONTHS YEAR TO DATE				
Actual	Budget	Bud Var	Prior Yr	PY Var		Actual	Budget	Bud Var	Prior Yr	PY Var
					Revenue, Gains and Support					
14,934,725	12,984,304	15.0%	12,861,105	16.1%	Patient Service Revenue, Net of Contractual Allowances and Discounts	170,677,822	157,853,038	8.1%	143,069,171	19.3%
(967,447)	(2,105,455)	54.1%	(2,183,663)	55.7%	Provision for Bad Debt	(20,575,519)	(25,430,908)	19.1%	(17,002,826)	-21.0%
13,967,277	10,878,849	28.4%	10,677,442	30.8%	**Net Patient Service Revenue**	150,102,303	132,422,130	13.4%	126,068,344	19.1%
0	0	0.0%	0	0.0%	Premium Revenue	0	0	0.0%	0	0.0%
1,630,152	398,987	308.6%	4,683,903	-65.2%	Net Investment Gain	3,168,693	1,922,546	64.8%	9,606,730	-67.0%
0	0	0.0%	0	0.0%	Net Derivative Gain	0	0	0.0%	0	0.0%
937,577	161,197	481.6%	3,289,327	-71.5%	Other Revenue, Gains and Support	2,800,711	1,904,926	47.0%	5,590,722	-49.9%
16,535,006	11,439,034	-44.5%	18,650,671	11.3%	**Total Revenue, Gains and Support**	156,071,707	136,249,601	-14.5%	141,263,797	-10.5%
					Expense					
3,821,667	3,020,489	-26.5%	3,415,738	-11.9%	Salaries and Wages	38,287,219	36,114,546	-6.0%	35,921,566	-6.6%
594,227	622,890	4.6%	1,148,004	48.2%	Provider Salaries	9,772,833	10,109,225	3.3%	14,467,792	32.5%
140,203	43,990	-218.7%	133,191	-5.3%	Contract Labor	1,442,268	790,864	-82.4%	682,573	-111.3%
1,236,682	940,901	-31.4%	583,372	-112.0%	Employee Benefits	10,586,163	9,591,700	-10.4%	8,892,782	-19.0%
1,843,922	1,481,240	-24.5%	1,477,358	-24.8%	Fees	20,794,956	18,136,282	-14.7%	19,593,842	-6.1%
1,951,820	1,706,429	-14.4%	2,081,079	6.2%	Supplies	22,269,900	20,653,207	-7.8%	19,567,473	-13.8%
145,288	175,786	17.3%	168,321	13.7%	Utilities	2,086,909	2,075,708	-0.5%	1,958,593	-6.6%
0	0	0.0%	0	0.0%	Medical Costs	0	0	0.0%	0	0.0%
1,014,329	856,322	-18.5%	969,502	-4.6%	Other Expense	10,358,305	10,559,317	1.9%	8,296,879	-24.8%
0	0	0.0%	0	0.0%	Loss on Extinguishment of LTD / Derivatives	0	0	0.0%	0	0.0%
1,016,073	1,143,186	11.1%	(551,290)	284.3%	Depreciation	12,050,832	13,177,926	8.6%	12,797,707	5.8%
3,418	3,418	0.0%	3,418	0.0%	Amortization	41,020	41,020	0.0%	41,020	0.0%
33,312	36,076	7.7%	44,115	24.5%	Interest & Taxes	446,090	482,914	7.6%	577,529	22.8%
115,305	220,291	47.7%	527,602	78.1%	Consolidation Allocation	2,627,862	2,750,966	4.5%	6,480,950	59.5%
11,916,248	10,251,018	-16.2%	10,000,410	-19.2%	**Total Expenses**	130,764,156	124,483,676	-5.0%	129,278,706	-1.1%
4,618,758	1,188,015	-288.8%	8,650,261	46.6%	**Excess of Revenue, Gains and Support over Expenses and Losses**	25,307,551	11,765,925	-115.1%	11,985,090	-111.2%

Johnston Memorial Consolidated

Comparative Balance Sheet

	June 30 2015	May 31 2015	Month Activity	June 30 2014	YTD Activity
ASSETS					
CURRENT ASSETS					
Cash and Cash Equivalents	10,296,333	9,701,014	595,319	11,653,780	(1,357,448)
Current Portion AWUIL	0	0	0	0	(0)
Accounts Receivable (Net)	22,263,497	21,319,582	943,915	21,666,369	597,128
Other Receivables	2,161,934	1,603,808	558,126	2,704,886	(542,952)
Due From Affiliates	181,489	2,826,927	(2,645,438)	391,998	(210,509)
Due From Third Party Payors	1,741,384	1,573,280	168,103	1,765,400	(24,017)
Inventories	2,946,517	3,028,826	(82,308)	2,957,365	(10,848)
Prepaid Expense	683,920	574,956	108,965	634,974	48,947
	40,275,074	40,628,392	(353,318)	41,774,772	(1,499,698)
ASSETS WHOSE USE IS LIMITED	0	0	0	0	(0)
OTHER INVESTMENTS	164,507,633	159,938,110	4,569,523	130,127,592	34,380,041
PROPERTY, PLANT AND EQUIPMENT					
Land, Buildings and Equipment	259,038,348	259,227,153	(188,805)	257,352,857	1,685,491
Less Allowances for Depreciation	101,420,225	100,474,207	946,018	90,051,499	11,368,726
	157,618,123	158,752,947	(1,134,824)	167,301,358	(9,683,235)
OTHER ASSETS					
Pledges Receivable	0	0	0	0	0
Long Term Compensation Investment	0	0	0	0	0
Investments in Unconsolidated Subsidiaries	199,510	199,510	0	199,510	0
Land / Equipment Held for Resale	0	0	0	0	0
Assets Held for Expansion	1,861,941	1,518,216	343,724	1,518,216	343,724
Investments in Subsidiaries	0	0	0	0	0
Goodwill	69,828	69,828	0	69,828	0
Deferred Charges and Other	207,711	211,130	(3,418)	248,732	(41,020)
	2,338,990	1,998,685	340,306	2,036,286	302,704
TOTAL ASSETS	364,739,821	361,318,134	3,421,687	341,240,009	23,499,812
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts Payable and Accrued Expense	5,803,072	3,953,561	1,849,511	5,403,497	399,575
Accrued Salaries, Benefits, and PTO	7,093,747	6,315,928	777,819	7,159,836	(66,089)
Claims Payable	0	0	0	0	0
Accrued Interest	34,163	35,263	(1,100)	35,014	(851)
Due to Affiliates	758,746	2,934,465	(2,175,719)	363,033	395,713
Due to Third Party Payors	2,261,850	2,261,850	0	2,261,850	0
Call Option Liability	0	0	0	0	0
Current Portion of Long Term Debt	17,564,742	1,498,276	16,066,467	3,042,473	14,522,270
	33,516,321	16,999,343	16,516,977	18,265,703	15,250,618
OTHER NON CURRENT LIABILITIES					
Long Term Compensation Payable	0	0	0	0	0
Long Term Debt	18,470,351	34,562,611	(16,092,259)	35,981,126	(17,510,775)
Estimated Fair Value of Interest Rate Swaps	0	0	0	0	0
Deferred Income	2,651,383	4,515,591	(1,864,208)	2,086,237	565,146
Professional Liability Self-Insurance and Other	1,013,939	771,520	242,419	1,126,666	(112,727)
	22,135,673	39,849,721	(17,714,049)	39,194,029	(17,058,357)
TOTAL LIABILITIES	55,651,994	56,849,065	(1,197,071)	57,459,732	(1,807,739)
NET ASSETS					
Restricted Net Assets	481	481	0	481	0
Unrestricted Net Assets	308,418,731	303,799,973	4,618,758	283,779,796	24,638,936
Noncontrolling Interests in Subsidiaries	668,615	668,615	0	0	668,615
	309,087,827	304,469,069	4,618,758	283,780,277	25,307,551
TOTAL LIABILITIES AND NET ASSETS	364,739,821	361,318,134	3,421,687	341,240,009	23,499,812

Johnston Memorial Hospital
Covenant Compliance Certificate

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

Status as of: 9/30/2013

Debt Service Coverage

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

Debt to Capital

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

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

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

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

Mountain States Health Alliance

By: _____

Print Name: John Veter

Title: Assistant Administrator & CFO

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 9/30/2014

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

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

Status as of: 12/31/2013

Debt Service Coverage

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

Debt to Capital

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

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

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

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

Mountain States Health Alliance

By: _____
Print Name: John Peter
Title: Assistant Administrator & CFO

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 12/31/2014

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

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

Status as of: 3/31/2014

Debt Service Coverage

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

Debt to Capital

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

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

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

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

Mountain States Health Alliance

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

Johnston Memorial Hospital
Covenant Compliance Certificate

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

Status as of: 3/31/2015

Debt Service Coverage

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

Debt to Capital

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

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

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

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

Status as of: 6/30/2014

Debt Service Coverage

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

Debt to Capital

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

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

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 6/30/2015

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 6/30/2015

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

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

MONTH OF JUNE						TWELVE MONTHS YEAR TO DATE				
Actual	Budget	Bud Var	Prior Yr	PY Var		Actual	Budget	Bud Var	Prior Yr	PY Var
					Operating Statistics (excl Long-Term Care)					
81	71	14.8%	71	14.3%	Average Daily Census	81	69	17.5%	64	26.1%
70.2%	61.1%	14.8%	61.4%	14.3%	Occupancy Percent	70.1%	59.6%	17.5%	55.6%	26.1%
2,444	2,128	14.8%	2,138	14.3%	Patient Days	29,660	25,232	17.5%	23,524	26.1%
739	639	15.6%	649	13.9%	Admissions	9,009	7,646	17.8%	7,109	26.7%
339	259	30.9%	299	13.4%	Observation Visits	3,816	3,717	2.7%	4,130	-7.6%
247	181	36.5%	201	22.9%	Non OB Observation Visits	2,816	2,625	7.3%	2,993	-5.9%
25.1%	22.1%	13.5%	23.6%	5.9%	Non OB Observation Visits % of Non OB Observation Visits & Acute Admissions	23.8%	25.6%	-6.8%	29.6%	-19.6%
7.9%	5.4%	46.3%	8.2%	-3.5%	Non OB Observation % of Occupancy	6.9%	6.5%	6.1%	10.4%	-34.4%
6,397	5,435	17.7%	5,966	7.2%	Adjusted Patient Days	75,521	66,126	14.2%	70,039	7.8%
1,934	1,632	18.5%	1,811	6.8%	Adjusted Admissions	22,939	20,038	14.5%	21,166	8.4%
20,286	17,993	12.7%	20,610	-1.6%	Outpatient Visits	229,145	221,374	3.5%	249,494	-8.2%
3,484	2,989	16.6%	3,275	6.4%	ED Visits	41,308	36,299	13.6%	39,161	5.5%
60	129	-53.5%	60	0.0%	Home Health Episodes	646	1,543	-58.1%	811	-20.3%
114	121	-5.8%	112	1.8%	IP Surgery Cases	1,468	1,443	1.7%	1,296	13.3%
476	460	3.5%	416	14.4%	OP Surgery Cases	5,265	5,655	-6.9%	5,560	-5.3%
					Revenue By Source					
36.1%	39.6%	-3.5%	36.7%	-0.6%	Medicare	38.1%	39.6%	-1.4%	39.5%	-1.3%
17.9%	13.3%	4.6%	12.8%	5.1%	Managed Medicare	15.5%	13.3%	2.2%	13.3%	2.2%
12.1%	13.9%	-1.8%	13.4%	-1.3%	Medicaid	12.2%	13.9%	-1.7%	13.6%	-1.4%
0.3%	0.3%	0.0%	0.4%	-0.1%	TennCare	0.4%	0.3%	0.1%	0.3%	0.0%
16.8%	16.3%	0.5%	18.3%	-1.5%	Blue Cross	17.1%	16.3%	0.8%	16.6%	0.5%
2.4%	1.7%	0.7%	1.7%	0.7%	United - River Valley	1.7%	1.7%	0.0%	1.7%	0.0%
6.7%	5.4%	1.3%	6.2%	0.4%	Managed Care / Commercial	5.6%	5.4%	0.3%	5.4%	0.2%
6.0%	7.8%	-1.9%	8.4%	-2.5%	Charity / Self Pay	7.5%	7.8%	-0.3%	8.0%	-0.4%
1.8%	1.7%	0.0%	2.1%	-0.3%	Other Patient Revenue	1.9%	1.7%	0.2%	1.7%	0.2%
100.0%	100.0%		100.0%		Total Gross Patient Revenue	100.0%	100.0%		100.0%	
$9,995	$10,453	-4.4%	$8,694	15.0%	IP Revenue per Patient Day	$8,368	$10,495	-10.7%	$8,794	6.5%
$1,948	$1,921	1.4%	$1,615	20.6%	OP Revenue per Outpatient Visit	$1,875	$1,939	-3.3%	$1,639	14.4%
$2,348	$2,033	15.5%	$2,237	5.0%	Operating Revenue per Adjusted Patient Day	$2,033	$2,035	-0.1%	$1,874	8.5%
$1,774	$1,886	5.9%	$1,590	-11.6%	Operating Expense per Adjusted Patient Day	$1,724	$1,883	8.4%	$1,888	6.2%
$7,766	$6,769	14.7%	$7,370	5.4%	Operating Revenue per Adjusted Admission	$8,892	$8,716	-0.4%	$8,201	7.9%
$5,868	$6,261	6.6%	$5,239	-12.0%	Operating Expense per Adjusted Admission	$5,876	$8,212	8.6%	$5,083	6.7%
21.8%	19.1%	14.1%	20.6%	6.1%	Net Revenue % of Gross Revenue	21.2%	19.1%	11.2%	20.5%	3.7%
$7,221	$6,666	8.3%	$5,896	22.5%	Net Revenue per Adjusted Admission	$8,544	$8,609	-1.0%	$5,956	9.9%
					Labor Management (excl Long-Term Care)					
902	815	-10.7%	794	-13.7%	Employed Full Time Equivalents	824	805	-2.3%	791	-4.2%
14	2	-453.7%	13	-8.7%	Contract Full Time Equivalents	10	4	-133.1%	5	-94.5%
916	818	-12.0%	806	-13.6%	Total Full Time Equivalents	834	810	-3.0%	796	-4.8%
4.30	4.51	4.8%	4.05	-6.0%	FTEs per Adjusted Occupied Bed (incl Cont Lbr)	4.03	4.47	9.6%	4.15	2.8%
81.0	85.6	5.5%	76.1	-6.4%	Man Hours per Adjusted Admission (incl Cont Lbr)	75.6	84.0	10.0%	78.2	3.3%
$21.10	$21.68	2.8%	$21.40	1.4%	Average Hourly Rate (excl Cont Lbr)	$22.01	$21.56	-2.1%	$21.52	-2.3%
$43,894	$45,084	2.6%	$44,502	1.4%	Salary Expense per FTE (excl Cont Lbr)	$45,780	$44,851	-2.1%	$44,762	-2.3%
$2,481	$2,548	2.6%	$2,070	-19.9%	Labor Exp (excl Phys) per Adjusted Admission	$2,245	$2,408	6.8%	$2,210	-1.6%
37.4%	42.5%	12.0%	44.7%	16.2%	Labor Exp % of Net Revenue	39.7%	42.7%	7.2%	47.1%	15.9%
					Patient Resource Management					
3.60	3.66	1.6%	3.51	-2.5%	Overall Medicare Average Length of Stay	3.58	3.62	1.1%	3.63	1.4%
3.31	3.33	0.7%	3.29	-0.4%	Overall Average Length of Stay	3.29	3.30	0.2%	3.31	0.5%
3.60	3.65	1.5%	3.55	-1.3%	Acute Medicare Average Length of Stay	3.58	3.62	1.1%	3.63	1.4%
2.49	2.85	12.7%	2.57	3.1%	Acute Medicare Average Length of Stay - Acuity Adjusted	2.57	2.83	9.0%	2.81	8.6%
3.31	3.33	0.7%	3.29	-0.4%	Acute Overall Average Length of Stay	3.29	3.30	0.2%	3.31	0.5%
2.42	2.80	13.5%	2.55	5.1%	Acute Overall Average Length of Stay - Acuity Adjusted	2.49	2.77	10.3%	2.76	10.0%
1.11	1.04	-7.2%	1.42	21.5%	Observation Average Length of Stay	1.03	1.04	1.1%	1.48	30.3%
1.44	1.28	12.6%	1.38	4.5%	Overall Medicare Case Mix Index	1.39	1.28	8.6%	1.29	7.9%
1.34	1.11	20.4%	1.22	9.6%	Overall Case Mix Index	1.30	1.11	16.7%	1.12	15.6%
1.44	1.28	12.6%	1.38	4.5%	Acute Medicare Case Mix Index	1.39	1.28	8.6%	1.29	7.8%
1.37	1.19	14.8%	1.29	5.8%	Acute Overall Case Mix Index	1.32	1.19	11.2%	1.20	10.6%
14.0%	15.7%	10.9%	19.5%	28.3%	Supply Expense % of Net Revenue	14.6%	15.6%	4.9%	15.5%	4.4%
$1,009	$1,046	3.5%	$1,149	12.2%	Supply Expense per Adjusted Admission	$971	$1,031	5.8%	$924	-5.0%

Johnston Memorial Consolidated

Statement of Revenue and Expense

For the Period Ended June 30, 2015

MONTH OF JUNE						TWELVE MONTHS YEAR TO DATE				
Actual	Budget	Bud Var	Prior Yr	PY Var		Actual	Budget	Bud Var	Prior Yr	PY Var
					Revenue, Gains and Support					
14,934,725	12,984,304	15.0%	12,861,105	16.1%	Patient Service Revenue, Net of Contractual Allowances and Discounts	170,677,822	157,853,038	8.1%	143,069,171	19.3%
(967,447)	(2,105,455)	54.1%	(2,183,663)	55.7%	Provision for Bad Debt	(20,575,519)	(25,430,908)	19.1%	(17,002,826)	-21.0%
13,967,277	10,878,849	28.4%	10,677,442	30.8%	**Net Patient Service Revenue**	150,102,303	132,422,130	13.4%	126,066,344	19.1%
0	0	0.0%	0	0.0%	Premium Revenue	0	0	0.0%	0	0.0%
1,630,152	398,987	308.6%	4,683,903	-65.2%	Net Investment Gain	3,168,693	1,922,546	64.8%	9,606,730	-67.0%
0	0	0.0%	0	0.0%	Net Derivative Gain	0	0	0.0%	0	0.0%
937,577	161,197	481.6%	3,289,327	-71.5%	Other Revenue, Gains and Support	2,800,711	1,904,926	47.0%	5,590,722	-49.9%
16,535,006	11,439,034	-44.5%	18,650,671	11.3%	**Total Revenue, Gains and Support**	156,071,707	136,249,601	-14.5%	141,263,797	-10.5%
					Expense					
3,821,667	3,020,489	-26.5%	3,415,738	-11.9%	Salaries and Wages	38,287,219	36,114,546	-6.0%	35,921,566	-6.6%
594,227	622,890	4.6%	1,148,004	48.2%	Provider Salaries	9,772,833	10,109,225	3.3%	14,467,792	32.5%
140,203	43,990	-218.7%	133,191	-5.3%	Contract Labor	1,442,268	790,864	-82.4%	682,573	-111.3%
1,236,682	940,901	-31.4%	583,372	-112.0%	Employee Benefits	10,586,163	9,591,700	-10.4%	8,892,782	-19.0%
1,843,922	1,481,240	-24.5%	1,477,358	-24.8%	Fees	20,794,956	18,136,282	-14.7%	19,593,842	-6.1%
1,951,820	1,706,429	-14.4%	2,081,079	6.2%	Supplies	22,269,900	20,653,207	-7.8%	19,567,473	-13.8%
145,288	175,786	17.3%	168,321	13.7%	Utilities	2,086,909	2,075,708	-0.5%	1,958,593	-6.6%
0	0	0.0%	0	0.0%	Medical Costs	0	0	0.0%	0	0.0%
1,014,329	856,322	-18.5%	969,502	-4.6%	Other Expense	10,358,305	10,559,317	1.9%	8,296,879	-24.8%
0	0	0.0%	0	0.0%	Loss on Extinguishment of LTD / Derivatives	0	0	0.0%	0	0.0%
1,016,073	1,143,186	11.1%	(551,290)	284.3%	Depreciation	12,050,632	13,177,926	8.6%	12,797,707	5.8%
3,418	3,418	0.0%	3,418	0.0%	Amortization	41,020	41,020	0.0%	41,020	0.0%
33,312	36,076	7.7%	44,115	24.5%	Interest & Taxes	446,090	482,914	7.6%	577,529	22.8%
115,305	220,291	47.7%	527,602	78.1%	Consolidation Allocation	2,627,862	2,750,966	4.5%	6,480,950	59.5%
11,916,248	10,251,018	-16.2%	10,000,410	-19.2%	**Total Expenses**	130,764,156	124,483,676	-5.0%	129,278,706	-1.1%
4,618,758	1,188,015	-288.8%	8,650,261	46.6%	**Excess of Revenue, Gains and Support over Expenses and Losses**	25,307,551	11,765,925	-115.1%	11,985,090	-111.2%

Johnston Memorial Consolidated

Comparative Balance Sheet

	June 30 2015	May 31 2015	Month Activity	June 30 2014	YTD Activity
ASSETS					
CURRENT ASSETS					
Cash and Cash Equivalents	10,296,333	9,701,014	595,319	11,653,780	(1,357,448)
Current Portion AWUIL	0	0	0	0	(0)
Accounts Receivable (Net)	22,263,497	21,319,582	943,915	21,666,369	597,128
Other Receivables	2,161,934	1,603,808	558,126	2,704,886	(542,952)
Due From Affiliates	181,489	2,826,927	(2,645,438)	391,998	(210,509)
Due From Third Party Payors	1,741,384	1,573,280	168,103	1,765,400	(24,017)
Inventories	2,946,517	3,028,826	(82,308)	2,957,365	(10,848)
Prepaid Expense	683,920	574,956	108,965	634,974	48,947
	40,275,074	40,628,392	(353,318)	41,774,772	(1,499,698)
ASSETS WHOSE USE IS LIMITED	0	0	0	0	(0)
OTHER INVESTMENTS	164,507,633	159,938,110	4,569,523	130,127,592	34,380,041
PROPERTY, PLANT AND EQUIPMENT					
Land, Buildings and Equipment	259,038,348	259,227,153	(188,805)	257,352,857	1,685,491
Less Allowances for Depreciation	101,420,225	100,474,207	946,018	90,051,499	11,368,726
	157,618,123	158,752,947	(1,134,824)	167,301,358	(9,683,235)
OTHER ASSETS					
Pledges Receivable	0	0	0	0	0
Long Term Compensation Investment	0	0	0	0	0
Investments in Unconsolidated Subsidiaries	199,510	199,510	0	199,510	0
Land / Equipment Held for Resale	0	0	0	0	0
Assets Held for Expansion	1,861,941	1,518,216	343,724	1,518,216	343,724
Investments in Subsidiaries	0	0	0	0	0
Goodwill	69,828	69,828	0	69,828	0
Deferred Charges and Other	207,711	211,130	(3,418)	248,732	(41,020)
	2,338,990	1,998,685	340,306	2,036,286	302,704
TOTAL ASSETS	364,739,821	361,318,134	3,421,687	341,240,009	23,499,812
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts Payable and Accrued Expense	5,803,072	3,953,561	1,849,511	5,403,497	399,575
Accrued Salaries, Benefits, and PTO	7,093,747	6,315,928	777,819	7,159,836	(66,089)
Claims Payable	0	0	0	0	0
Accrued Interest	34,163	35,263	(1,100)	35,014	(851)
Due to Affiliates	758,746	2,934,465	(2,175,719)	363,033	395,713
Due to Third Party Payors	2,261,850	2,261,850	0	2,261,850	0
Call Option Liability	0	0	0	0	0
Current Portion of Long Term Debt	17,564,742	1,498,276	16,066,467	3,042,473	14,522,270
	33,516,321	16,999,343	16,516,977	18,265,703	15,250,618
OTHER NON CURRENT LIABILITIES					
Long Term Compensation Payable	0	0	0	0	0
Long Term Debt	18,470,351	34,562,611	(16,092,259)	35,981,126	(17,510,775)
Estimated Fair Value of Interest Rate Swaps	0	0	0	0	0
Deferred Income	2,651,383	4,515,591	(1,864,208)	2,086,237	565,146
Professional Liability Self-Insurance and Other	1,013,939	771,520	242,419	1,126,666	(112,727)
	22,135,673	39,849,721	(17,714,049)	39,194,029	(17,058,357)
TOTAL LIABILITIES	55,651,994	56,849,065	(1,197,071)	57,459,732	(1,807,739)
NET ASSETS					
Restricted Net Assets	481	481	0	481	0
Unrestricted Net Assets	308,418,731	303,799,973	4,618,758	283,779,796	24,638,936
Noncontrolling Interests in Subsidiaries	668,615	668,615	0	0	668,615
	309,087,827	304,469,069	4,618,758	283,780,277	25,307,551
TOTAL LIABILITIES AND NET ASSETS	364,739,821	361,318,134	3,421,687	341,240,009	23,499,812

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 9/30/2014

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 9/30/2015

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

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

Status as of: 12/31/2013

Debt Service Coverage

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

Debt to Capital

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

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

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

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

Mountain States Health Alliance

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

Johnston Memorial Hospital

Covenant Compliance Certificate

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

Status as of: 12/31/2014

Debt Service Coverage

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

Debt to Capital

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2015

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States HealthAlliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2015

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: 

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2015

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2015

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

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

Status as of: 3/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 49,107
+ Depreciation	$ 55,307
+ Amortization	$ 4,903
+ Interest Expense	$ 43,995
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 146,827
Total Debt Service (MADS)	$ 65,782
Debt Service Coverage Ratio	2.23x
Covenant Requirement	1.30x

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

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

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

Mountain States Health Alliance

By: Mark Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2012

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 60,483
+ Depreciation	$ 61,111
+ Amortization	$ 2,211
+ Interest Expense	$ 42,464
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	
EBITDA	$ 151,293
Total Debt Service (MADS)	$ 67,625
Debt Service Coverage Ratio	2.24x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2012

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Mark Eich

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	**$ 42,447**
+ Depreciation	$ 47,707
+ Amortization	$ 10,205
+ Interest Expense	$ 39,725
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	
EBITDA	$ 142,532
Total Debt Service (MADS)	$ 77,187
Debt Service Coverage Ratio	**1.85x**
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	**$ 50,451**
+ Depreciation	$ 57,953
+ Amortization	$ 2,233
+ Interest Expense	$ 39,882
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	
EBITDA	$ 146,901
Total Debt Service (MADS)	$ 65,667
Debt Service Coverage Ratio	**2.24x**
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 50,630
+ Depreciation	$ 56,521
+ Amortization	$ 2,298
+ Interest Expense	$ 40,934
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	$ (2,553)
EBITDA	$ 148,107
Total Debt Service (MADS)	$ 69,270
Debt Service Coverage Ratio	2.14x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

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

Status as of: 12/31/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 43,001
+ Depreciation	$ 51,625
+ Amortization	$ 7,538
+ Interest Expense	$ 42,968
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 140,875
Total Debt Service (MADS)	$ 69,886
Debt Service Coverage Ratio	2.02x
Covenant Requirement	1.30x

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

Cash	$ 167,099
Unrestricted Investments	$ 183,585
Total Cash	$ 350,684
Total Operating Expenses (Including Interest)	$ 686,573
less: Non Cash Expenses	$ 59,163
Total Cash Expenses (TTM)	$ 627,410
Daily Cash Expenses	$ 1,719
Days Cash on Hand Ratio	204 Days
Covenant Requirement	100 Days

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

Mountain States Health Alliance

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

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 39,641
+ Depreciation	$ 57,427
+ Amortization	$ 2,268
+ Interest Expense	$ 39,479
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 146,118
Total Debt Service (MADS)	$ 65,751
Debt Service Coverage Ratio	2.22x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	$ 57,213
Unrestricted Investments	$ 320,881
Total Cash	$ 378,094
Total Operating Expenses (Including Interest)	$ 747,286
less: Non Cash Expenses	$ 59,695
Total Cash Expenses (TTM)	$ 687,591
Daily Cash Expenses	$ 1,884
Days Cash on Hand Ratio	201 Days
Covenant Requirement	100 Days

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	**$ 64,402**
+ Depreciation	$ 55,601
+ Amortization	$ 2,235
+ Interest Expense	$ 40,618
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	
EBITDA	$ 153,182
Total Debt Service (MADS)	$ 69,404
Debt Service Coverage Ratio	**2.21x**
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	$ 48,185
Unrestricted Investments	$ 335,612
Total Cash	**$ 383,797**
Total Operating Expenses (Including Interest)	$ 794,117
less: Non Cash Expenses	$ 57,836
Total Cash Expenses (TTM)	**$ 736,281**
Daily Cash Expenses	**$ 2,017**
Days Cash on Hand Ratio	**190 Days**
Covenant Requirement	100 Days

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

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

Status as of: 3/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 49,107
+ Depreciation	$ 65,307
+ Amortization	$ 4,903
+ Interest Expense	$ 43,995
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 146,827
Total Debt Service (MADS)	$ 65,782
Debt Service Coverage Ratio	2.23x
Covenant Requirement	1.30x

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

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

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

Mountain States Health Alliance

By: 

Print Name: Marvin Elchorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2012

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2014

Debt Service Coverage

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

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

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Heaith Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2015

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 60,483
+ Depreciation	$ 61,111
+ Amortization	$ 2,211
+ Interest Expense	$ 42,464
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	
EBITDA	$ 151,293
Total Debt Service (MADS)	$ 67,625
Debt Service Coverage Ratio	2.24x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	$ 86,426
Unrestricted Investments	$ 284,871
Total Cash	$ 371,297
Total Operating Expenses (Including Interest)	$ 699,129
less: Non Cash Expenses	$ 63,322
Total Cash Expenses (TTM)	$ 635,807
Daily Cash Expenses	$ 1,742
Days Cash on Hand Ratio	213 Days
Covenant Requirement	100 Days

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

Mountain States Health Alliance

By: 

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

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

Status as of: 6/30/2012

Debt Service Coverage

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

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

Cash	$ 38,364
Unrestricted Investments	$ 329,369
Total Cash	$ 367,733
Total Operating Expenses (Including Interest)	$ 792,216
less: Non Cash Expenses	$ 55,098
Total Cash Expenses (TTM)	$ 737,117
Daily Cash Expenses	$ 2,019
Days Cash on Hand Ratio	182 Days
Covenant Requirement	100 Days

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2015

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	**$ 42,447**
+ Depreciation	$ 47,707
+ Amortization	$ 10,205
+ Interest Expense	$ 39,725
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	
EBITDA	$ 142,532
Total Debt Service (MADS)	$ 77,187
Debt Service Coverage Ratio	**1.85x**
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Mark Eichs

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 50,451
+ Depreciation	$ 57,953
+ Amortization	$ 2,233
+ Interest Expense	$ 39,882
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 146,901
Total Debt Service (MADS)	$ 65,667
Debt Service Coverage Ratio	2.24x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 50,630
+ Depreciation	$ 56,521
+ Amortization	$ 2,298
+ Interest Expense	$ 40,934
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	$ (2,553)
EBITDA	$ 148,107
Total Debt Service (MADS)	$ 69,270
Debt Service Coverage Ratio	**2.14x**
Covenant Requirement	1.30x

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

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

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

Status as of: 12/31/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 43,001
+ Depreciation	$ 51,625
+ Amortization	$ 7,538
+ Interest Expense	$ 42,968
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 140,875
Total Debt Service (MADS)	$ 69,886
Debt Service Coverage Ratio	2.02x
Covenant Requirement	1.30x

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

Cash	$ 167,099
Unrestricted Investments	$ 183,585
Total Cash	$ 350,684
Total Operating Expenses (Including Interest)	$ 686,573
less: Non Cash Expenses	$ 59,163
Total Cash Expenses (TTM)	$ 627,410
Daily Cash Expenses	$ 1,719
Days Cash on Hand Ratio	204 Days
Covenant Requirement	100 Days

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

Mountain States Health Alliance

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

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 39,641
+ Depreciation	$ 57,427
+ Amortization	$ 2,268
+ Interest Expense	$ 39,479
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 146,118
Total Debt Service (MADS)	$ 65,751
Debt Service Coverage Ratio	2.22x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	$ 57,213
Unrestricted Investments	$ 320,881
Total Cash	$ 378,094
Total Operating Expenses (Including Interest)	$ 747,286
less: Non Cash Expenses	$ 59,695
Total Cash Expenses (TTM)	$ 687,591
Daily Cash Expenses	$ 1,884
Days Cash on Hand Ratio	201 Days
Covenant Requirement	100 Days

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

Mountain States Health Alliance

By: Marvin H. Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ **64,402**
+ Depreciation	$ 55,601
+ Amortization	$ 2,235
+ Interest Expense	$ 40,618
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	
EBITDA	$ 153,182
Total Debt Service (MADS)	$ 69,404
Debt Service Coverage Ratio	**2.21x**
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	$ 48,185
Unrestricted Investments	$ 335,612
Total Cash	$ **383,797**
Total Operating Expenses (Including Interest)	$ 794,117
less: Non Cash Expenses	$ 57,836
Total Cash Expenses (TTM)	$ **736,281**
Daily Cash Expenses	$ **2,017**
Days Cash on Hand Ratio	**190 Days**
Covenant Requirement	100 Days

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: 

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2015

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2015

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between SunTrust Bank and Mounatin States Health Alliance dated July 29, 2013, we hereby represent and warrant as follows:

Status as of: 9/30/2013

Debt Service Coverage

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

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

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

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 29, 2013.

Mountain States Health Alliance

By: Marvin Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2014

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: Lynn Krutak

Print Name: Lynn Krutak

Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2013

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

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

Status as of: 3/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 49,107
+ Depreciation	$ 55,307
+ Amortization	$ 4,903
+ Interest Expense	$ 43,895
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 146,827
Total Debt Service (MADS)	$ 65,782
Debt Service Coverage Ratio	2.23x
Covenant Requirement	1.30x

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

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

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

Mountain States Health Alliance

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

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 3/31/2012

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: 

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending March 31, 2013, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Name: Marvin Eichorn
Title: Senior Vice President, CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 3/31/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 59,288
Plus:	
Depreciation and amortization	$ 58,706
Interest Expense	$ 40,547
Unrealized losses (gains)	$ (7,157)
Extraordinary expenses	$ -
(LOC fees included in interest expense)	$ (5,351)
(Interest on Trusteed Funds)	$ (641)
Net Income Available for Debt Service	$ 145,392
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 69,393
Debt Service Coverage Calculated	2.10x
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ -
Operating Expenses	$ -
Less:	
Depreciation and Amortization	$ -
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ -
Day of Cash Operating Expenses	$ -
Days Cash on Hand Calculated	N/A Days
Minimum Days Cash on Hand Required	100 Days

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending March 31, 2014, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Name: Marvin Fichorn
Title: Senior VP, CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 3/31/14

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 29,567
Plus:	
Depreciation and amortization	$ 62,537
Interest Expense	$ 42,191
Unrealized losses (gains)	$ (36,729)
Extraordinary expenses	$ 4,622
(LOC fees included in interest expense)	$ (3,314)
(Interest on Trusteed Funds)	$ (869)
Net Income Available for Debt Service	$ 98,005
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 67,267
Debt Service Coverage Calculated	**1.46x**
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ -
Operating Expenses	$ -
Less:	
Depreciation and Amortization	$ -
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ -
Day of Cash Operating Expenses	$ -
Days Cash on Hand Calculated	**N/A Days**
Minimum Days Cash on Hand Required	100 Days

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending March 31, 2015 in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: Lynn Krutak
Name: Lynn Krutak
Title: Senior Vice President, CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 3/31/2015

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 24,015
Plus:	
Depreciation and amortization	$ 49,891
Interest Expense	$ 43,382
Unrealized losses (gains)	$ (718)
Extraordinary expenses	$ 4,622
(LOC fees included in interest expense)	$ (2,214)
(Interest on Trusteed Funds)	$ (381)
Net Income Available for Debt Service	$ 118,597
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 67,246
Debt Service Coverage Calculated	**1.76x**
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ -
Operating Expenses	$ -
Less:	
Depreciation and Amortization	$ -
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ -
Day of Cash Operating Expenses	$ -
Days Cash on Hand Calculated	**N/A Days**
Minimum Days Cash on Hand Required	100 Days

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 60,483
+ Depreciation	$ 61,111
+ Amortization	$ 2,211
+ Interest Expense	$ 42,464
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 151,293
Total Debt Service (MADS)	$ 67,625
Debt Service Coverage Ratio	2.24x
Covenant Requirement	1.30x

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

Cash	$ 86,426
Unrestricted Investments	$ 284,871
Total Cash	$ 371,297
Total Operating Expenses (including Interest)	$ 699,129
less: Non Cash Expenses	$ 63,322
Total Cash Expenses (TTM)	$ 635,807
Daily Cash Expenses	$ 1,742
Days Cash on Hand Ratio	213 Days
Covenant Requirement	100 Days

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

Mountain States Health Alliance

By: 

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 6/30/2012

Debt Service Coverage

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

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Etchorn

Title: Senior Vice President & CFO

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending June 30 2013, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: /s/ Marvin Eichorn
Name: Marvin Eichorn
Title: Senior VP, CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 6/30/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 68,859
Plus:	
Depreciation and amortization	$ 60,499
Interest Expense	$ 41,226
Unrealized losses (gains)	$ (19,278)
Extraordinary expenses	$ -
(LOC fees included in interest expense)	$ (5,412)
(Interest on Trusteed Funds)	$ (833)
Net Income Available for Debt Service	$ 145,061
Maximum Annual Debt Service on all Outstanding indebtedness	$ 69,360
Debt Service Coverage Calculated	**2.09x**
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ 400,991
Operating Expenses	$ 800,349
Less:	
Depreciation and Amortization	$ 60,499
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ 739,850
Day of Cash Operating Expenses	$ 2,027
Days Cash on Hand Calculated	198 Days
Minimum Days Cash on Hand Required	100 Days

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____.

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____.

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending June 30, 2014, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

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

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 6/30/2014

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 43,636
Plus:	
Depreciation and amortization	$ 54,235
Interest Expense	$ 42,734
Unrealized losses (gains)	$ (28,296)
Extraordinary expenses	$ 4,622
(LOC fees included in interest expense)	$ (2,537)
(Interest on Trusteed Funds)	$ (666)
Net Income Available for Debt Service	$ 113,728
Maximum Annual Debt Service on all Outstanding indebtedness	$ 67,257
Debt Service Coverage Calculated	**1.69x**
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ 422,765
Operating Expenses	$ 825,612
Less:	
Depreciation and Amortization	$ 54,235
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ 771,377
Day of Cash Operating Expenses	$ 2,113
Days Cash on Hand Calculated	200 Days
Minimum Days Cash on Hand Required	100 Days

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending June 30, 2015, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: Lynn Krutak
Name: Lynn Krutak
Title: Senior VP & CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 06/30/2015

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 30,423
Plus:	
Depreciation and amortization	$ 52,796
Interest Expense	$ 41,598
Unrealized losses (gains)	$ 3,348
Extraordinary expenses	$ -
(LOC fees included in interest expense)	$ (2,183)
(Interest on Trusteed Funds)	$ (321)
Net Income Available for Debt Service	$ 125,661
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 67,254
Debt Service Coverage Calculated	**1.87x**
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ 454,956
Operating Expenses	$ 829,866
Less:	
Depreciation and Amortization	$ 52,796
Other excluded expenses	$ -
Total Cash Expenses (TTM)	**$ 777,070**
Day of Cash Operating Expenses	$ 2,129
Days Cash on Hand Calculated	214 Days
Minimum Days Cash on Hand Required	100 Days

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 42,447
+ Depreciation	$ 47,707
+ Amortization	$ 10,205
+ Interest Expense	$ 39,725
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary items	
EBITDA	$ 142,532
Total Debt Service (MADS)	$ 77,187
Debt Service Coverage Ratio	1.85x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Elchorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 9/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 50,451
+ Depreciation	$ 57,953
+ Amortization	$ 2,233
+ Interest Expense	$ 39,682
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 146,901
Total Debt Service (MADS)	$ 65,667
Debt Service Coverage Ratio	2.24x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

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

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

Mountain States Health Alliance

By: 

Print Name: Marvin Elchorn

Title: Senior Vice President & CFO

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending September 30, 2012, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Name: Marvin H Eichorn
Title: Senior Vice President & CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 9/30/2012

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 50,630
Plus:	
Depreciation and amortization	$ 58,819
Interest Expense	$ 40,934
Unrealized losses (gains)	$ (4,829)
Extraordinary expenses	$ (2,553)
(LOC fees included in interest expense)	$ (5,261)
(Interest on Trusteed Funds)	$ (580)
Net Income Available for Debt Service	$ 137,160
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 69,270
Debt Service Coverage Calculated	**1.98x**
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ -
Operating Expenses	$ -
Less:	
Depreciation and Amortization	$ -
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ -
Day of Cash Operating Expenses	$ -
Days Cash on Hand Calculated	**N/A Days**
Minimum Days Cash on Hand Required	100 Days

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending September 30 2013, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

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

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 9/30/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 62,408
Plus:	
Depreciation and amortization	$ 62,003
Interest Expense	$ 41,609
Unrealized losses (gains)	$ (34,920)
Extraordinary expenses	$ -
(LOC fees included in interest expense)	$ (4,887)
(Interest on Trusteed Funds)	$ (765)
Net Income Available for Debt Service	$ 125,448
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 67,286
Debt Service Coverage Calculated	1.86x
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ -
Operating Expenses	$ -
Less:	
Depreciation and Amortization	$ -
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ -
Day of Cash Operating Expenses	$ -
Days Cash on Hand Calculated	N/A Days
Minimum Days Cash on Hand Required	100 Days

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending September 30, 2014, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: Lynn Krutak
Name: Lynn Krutak
Title: Senior Vice President + CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 9/30/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	**$ 28,275**
Plus:	
Depreciation and amortization	$ 52,883
Interest Expense	$ 42,901
Unrealized losses (gains)	$ 9,078
Extraordinary expenses	$ -
(LOC fees included in interest expense)	$ (2,190)
(Interest on Trusteed Funds)	$ (614)
Net Income Available for Debt Service	$ 130,333
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 67,252
Debt Service Coverage Calculated	**1.94x**
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ -
Operating Expenses	$ -
Less:	
Depreciation and Amortization	$ -
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ -
Day of Cash Operating Expenses	$ -
Days Cash on Hand Calculated	**N/A Days**
Minimum Days Cash on Hand Required	100 Days

Mountain States Health Alliance
Covenant Compliance Certificate

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

Status as of: 12/31/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 43,001
+ Depreciation	$ 51,625
+ Amortization	$ 7,538
+ Interest Expense	$ 42,968
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 140,875
Total Debt Service (MADS)	$ 69,886
Debt Service Coverage Ratio	2.02x
Covenant Requirement	1.30x

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

Cash	$ 167,099
Unrestricted Investments	$ 183,585
Total Cash	$ 350,684
Total Operating Expenses (Including Interest)	$ 686,573
less: Non Cash Expenses	$ 59,163
Total Cash Expenses (TTM)	$ 627,410
Daily Cash Expenses	$ 1,719
Days Cash on Hand Ratio	204 Days
Covenant Requirement	100 Days

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

Mountain States Health Alliance

By: _____

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

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

Status as of: 12/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 39,641
+ Depreciation	$ 57,427
+ Amortization	$ 2,268
+ Interest Expense	$ 39,479
+ Taxes	$ -
+ Non-Cash Impairment Losses	$ -
+ Extraordinary Items	
EBITDA	$ 146,118
Total Debt Service (MADS)	$ 66,751
Debt Service Coverage Ratio	2.22x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	$ 57,213
Unrestricted Investments	$ 320,881
Total Cash	$ 378,094
Total Operating Expenses (Including Interest)	$ 747,286
less: Non Cash Expenses	$ 59,695
Total Cash Expenses (TTM)	$ 687,591
Daily Cash Expenses	$ 1,884
Days Cash on Hand Ratio	201 Days
Covenant Requirement	100 Days

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

Mountain States Health Alliance

By: Marvin H Eichorn

Print Name: Marvin Eichorn

Title: Senior Vice President & CFO

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending December 31, 2012, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Name: Marvin Eichorn
Title: Senior VP & CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 12/31/2012

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 64,402
Plus:	
Depreciation and amortization	$ 57,836
Interest Expense	$ 40,618
Unrealized losses (gains)	$ (9,675)
Extraordinary expenses	$ -
(LOC fees included in interest expense)	$ (5,301)
(Interest on Trusteed Funds)	$ (587)
Net Income Available for Debt Service	$ 147,293
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 69,404
Debt Service Coverage Calculated	**2.12x**
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ 383,797
Operating Expenses	$ 794,117
Less:	
Depreciation and Amortization	$ 57,836
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ 736,281
Day of Cash Operating Expenses	$ 2,017
Days Cash on Hand Calculated	**190 Days**
Minimum Days Cash on Hand Required	100 Days

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending December 31, 2013, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

Marvin Eichorn

By: _____
Name: Marvin Eichorn
Title: Senior Vice President, CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 12/31/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 54,489
Plus:	
Depreciation and amortization	$ 62,711
Interest Expense	$ 41,619
Unrealized losses (gains)	$ (40,999)
Extraordinary expenses	$ 4,622
(LOC fees included in interest expense)	$ (4,285)
(Interest on Trusteed Funds)	$ (902)
Net Income Available for Debt Service	$ 117,255
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 67,281
Debt Service Coverage Calculated	1.74x
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ 397,095
Operating Expenses	$ 821,779
Less:	
Depreciation and Amortization	$ 62,711
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ 759,068
Day of Cash Operating Expenses	$ 2,080
Days Cash on Hand Calculated	191 Days
Minimum Days Cash on Hand Required	100 Days

EXHIBIT F

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____
_____
_____
_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____
_____
_____
_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending December 31, 2014, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: Lynn Krutak
Name: Lynn Krutak
Title: Senior Vice President, CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 12/31/2014

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	$ 28,210
Plus:	
Depreciation and amortization	$ 51,524
Interest Expense	$ 42,765
Unrealized losses (gains)	$ 22,696
Extraordinary expenses	$ -
(LOC fees included in interest expense)	$ (2,245)
(Interest on Trusteed Funds)	$ (451)
Net Income Available for Debt Service	$ 142,499
Maximum Annual Debt Service on all Outstanding Indebtedness	$ 67,240
Debt Service Coverage Calculated	2.12x
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	$ 426,396
Operating Expenses	$ 820,364
Less:	
Depreciation and Amortization	$ 51,524
Other excluded expenses	$ -
Total Cash Expenses (TTM)	$ 768,840
Day of Cash Operating Expenses	$ 2,106
Days Cash on Hand Calculated	202 Days
Minimum Days Cash on Hand Required	100 Days

Exhibit 11.4

Attachment E

Mountain States Officer's Certificates

PYA
Pershing Yoakley & Associates
CERTIFIED PUBLIC ACCOUNTANTS

Pershing Yoakley & Associates, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
(p) (865) 673-0844 (f) (865) 673-0173
(w) www.pyapc.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the consolidated financial statements of Mountain States Health Alliance and subsidiaries for the year ended June 30, 2010, and have issued our report thereon dated October 25, 2010. We have also audited the accompanying schedule of the historical debt service coverage ratio and historical maximum annual debt service coverage ratio of the Mountain States Health Alliance Obligated Group (the Group) for the year ended June 30, 2010 as defined by the Amended and Restated Master Trust Indenture dated February 1, 2000. This schedule is the responsibility of the Group's management. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit of the schedule in accordance with auditing standards generally accepted in the United States of America. Those standard require that we plan and perform the audit to obtain reasonable assurance about whether the schedule is free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purposes of expressing an opinion on the effectiveness of the Group's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the schedule. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall schedule presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, the historical debt service coverage ratio and the historical maximum annual debt service coverage ratio of the Group for the year ended June 30, 2010, in conformity with the Amended and Restated Master Trust Indenture dated February 1, 2000.

This report is intended solely for the information and use of the board of directors and management of Mountain States Health Alliance and the Bank of New York, as Master Trustee under the Amended and Restated Master Trust Indenture dated February 1, 2000, and is not intended to be and should not be used by anyone other these those specified parties.

Knoxville, Tennessee
October 25, 2010

Pershing Yoakley & Associates, P.C.

OFFICER'S CERTIFICATE

TO: The Bank of New York, Master Trustee

In accordance with Article Six, Section 6.6 (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York, the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000 The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2010 is 2.08 to 1 00. The Historical Maximum Annual Debt Service Coverage ratio of the Obligated Group for the year ended June 30, 2010 is 1.83 to 1.00.

A report from the independent auditor whose report accompanies the audited financial statements of the Obligated Group and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.

Marvin Eichorn, Senior Vice President and
Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

HISTORICAL DEBT SERVICE COVERAGE RATIO
and
HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO

MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP
(Dollars in Thousands)

Year Ended June 30, 2010

Income available for debt service - Historical	$ 136,023
Income available for maximum annual debt service	$ 141,077
Historical debt service requirement	$ 65,285
Historical maximum annual debt service requirement	$ 77,187
Historical debt service coverage ratio	2.08
Historical maximum annual debt service coverage ratio	1.83

PERSHING YOAKLEY & ASSOCIATES

PERSHING YOAKLEY & ASSOCIATES, P.C.
Certified Public Accountants
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919

p: (865) 673-0844 | f: (865) 673-0173
www.pyapc.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the consolidated financial statements of Mountain States Health Alliance for the year ended June 30, 2011, and have issued our report thereon dated October 26, 2011. We have also audited the accompanying schedule of the historical debt service coverage ratio and historical maximum annual debt service coverage ratio of the Mountain States Health Alliance Obligated Group (the Group) for the year ended June 30, 2011 as defined by the Amended and Restated Master Trust Indenture dated February 1, 2000. This schedule is the responsibility of the Group's management. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit of the schedule in accordance with auditing standards generally accepted in the United States of America. Those standard require that we plan and perform the audit to obtain reasonable assurance about whether the schedule is free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purposes of expressing an opinion on the effectiveness of the Group's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the schedule. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall schedule presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, the historical debt service coverage ratio and the historical maximum annual debt service coverage ratio of the Group for the year ended June 30, 2011, in conformity with the Amended and Restated Master Trust Indenture dated February 1, 2000.

This report is intended solely for the information and use of the Board of Directors and management of Mountain States Health Alliance and the Bank of New York Mellon Trust Company, N.A., as Master Trustee under the Amended and Restated Master Trust Indenture dated February 1, 2000, and is not intended to be and should not be used by anyone other these those specified parties.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
October 26, 2011

MOUNTAIN STATES
HEALTH ALLIANCE

OFFICER'S CERTIFICATE

TO: The Bank of New York, Master Trustee

In accordance with Article Six, Section 6.6. (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York, the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000. The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2011 is 2.17 to 1.00. The Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2011 is 2.26 to 1.00.

A report from the independent auditor whose report accompanies the audited consolidated financial statements and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.

Marvin Eichorn, Senior Vice President and
Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

HISTORICAL DEBT SERVICE COVERAGE RATIO
and
HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO

MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP
(Dollars in Thousands)

Year Ended June 30, 2011

Income available for debt service - Historical	$ 145,340
Income available for maximum annual debt service	$ 148,528
Historical debt service requirement	$ 67,129
Historical maximum annual debt service requirement	$ 65,678
Historical debt service coverage ratio	2.17
Historical maximum annual debt service coverage ratio	2.26

PYA
Certified Public Accountants

PERSHING YOAKLEY & ASSOCIATES, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
www.pyapc.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the consolidated financial statements of Mountain States Health Alliance for the year ended June 30, 2012, and have issued our report thereon dated October 26, 2012. We have also audited the accompanying schedule of the historical debt service coverage ratio and historical maximum annual debt service coverage ratio of the Mountain States Health Alliance Obligated Group (the Group) for the year ended June 30, 2012 as defined by the Amended and Restated Master Trust Indenture dated February 1, 2000. This schedule is the responsibility of the Group's management. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit of the schedule in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the schedule is free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purposes of expressing an opinion on the effectiveness of the Group's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the schedule. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall schedule presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, the historical debt service coverage ratio and the historical maximum annual debt service coverage ratio of the Group for the year ended June 30, 2012, in conformity with the Amended and Restated Master Trust Indenture dated February 1, 2000.

This report is intended solely for the information and use of the Board of Directors and management of Mountain States Health Alliance and the Bank of New York Mellon Trust Company, N.A., as Master Trustee under the Amended and Restated Master Trust Indenture dated February 1, 2000, and is not intended to be and should not be used by anyone other these those specified parties.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
October 26, 2012

OFFICER'S CERTIFICATE

TO: The Bank of New York Mellon Trust Company, N.A., Master Trustee

In accordance with Article Six, Section 6.6. (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York Mellon Trust Company, N.A., the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000. The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2012 is 1.33 to 1.00. The Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2012 is 1.89 to 1.00.

A report from the independent auditor whose report accompanies the audited consolidated financial statements and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.

Marvin Eichorn, Senior Vice President and
Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

HISTORICAL DEBT SERVICE COVERAGE RATIO
and
HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO
MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP
(Dollars in Thousands)
Year Ended June 30, 2012

Income available for debt service - Historical	$	145,011
Income available for maximum annual debt service	$	145,732
Historical debt service requirement	$	61,573
Historical maximum annual debt service requirement	$	77,211
Historical debt service coverage ratio		2.36
Historical maximum annual debt service coverage ratio		1.89

OFFICER'S CERTIFICATE

TO: The Bank of New York Mellon Trust Company, N.A., Master Trustee

In accordance with Article Six, Section 6.6. (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York Mellon Trust Company, N.A., the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000. The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2013 is 2.02 to 1.00. The Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2013 is 1.80 to 1.00.

A report from the independent auditor whose report accompanies the audited consolidated financial statements and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.

Marvin Eichorn, Senior Vice President and
Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

HISTORICAL DEBT SERVICE COVERAGE RATIO
and
HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO
MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP
(Dollars in Thousands)
Year Ended June 30, 2013

Income available for debt service - Historical	$	132,740
Income available for maximum annual debt service	$	133,035
Historical debt service requirement	$	65,870
Historical maximum annual debt service requirement	$	73,739
Historical debt service coverage ratio		2.02
Historical maximum annual debt service coverage ratio		1.80

OFFICER'S CERTIFICATE

TO: The Bank of New York Mellon Trust Company, N.A., Master Trustee

In accordance with Article Six, Section 6.6. (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York Mellon Trust Company, N.A., the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000. The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2014 is 1.82 to 1.00. The Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2014 is 1.75 to 1.00.

A report from the independent auditor whose report accompanies the audited consolidated financial statements and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.

Lynn Krutak

Lynn Krutak, Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

HISTORICAL DEBT SERVICE COVERAGE RATIO

and

HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO

MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP

(Dollars in Thousands)

Year Ended June 30, 2014

Income available for debt service - Historical	$	129,019
Income available for maximum annual debt service	$	129,271
Historical debt service requirement	$	70,802
Historical maximum annual debt service requirement	$	73,905
Historical debt service coverage ratio		1.82
Historical maximum annual debt service coverage ratio		1.75

Wellmont Health System Response to Additional Request from the Tennessee Office of the Attorney General
Submitted July 1, 2016

IN THE MATTER OF: Proposed Merger of Wellmont Health System and Mountain States Health Alliance, and other related entities which, or person whose, identities are not presently known

Table of Contents

Request 9

Exhibit 9 List of Providers on whose behalf a Party Negotiates with Health Insurance Plans (WHS27)

Request 10

Exhibit 10 List of Documents Relating to Party's Existing and Future Relationship with East Tennessee State University and any other College or University (WHS28-WHS32)

Request 11

Exhibit 11 List of Documents Relating to the Party's Current Relationship with East Tennessee Children's Hospital (WHS33-WHS34)

Request 12

Exhibit 12 Current Hospital Bed Counts for Competing Hospitals in the Geographic Region (WHS35-WHS36)

Request 13

Exhibit 13 Current Volume Outcomes for Wellmont and Mountain States and Duplication of Services (WHS37-WHS44)

Request 14

Exhibit 14 Documents Related to Wellmont's Physician Recruitment Efforts (WHS45)

Request 15

Exhibit 15 Current Duplication of Services (WHS46-WHS48)

April 20, 2016
Additional Request from the Attorney General's Office
Wellmont Response

1. **Documents relating to the other nine bids/proposals that were submitted to and considered by the Board of WHS.**

   RESPONSE: The documents relating to the other nine bids/proposals were submitted by Wellmont on May 12, 2016 pursuant to CID.

2. **Documents relating to both merging parties' plans for electronic health records systems, including documents showing the current system each party is using, plans to convert to a single records system, including a timeline, the expected benefits of the system versus using the health information exchange, and any consulting reports.**

   RESPONSE: A description of both Parties' plans for electronic health records systems including information about the current system each party is using, plans to convert to a single records system, a timeline, and the expected benefits of the system versus using the health information exchange is attached as Exhibit 2. Wellmont does not have any consulting reports responsive to this request.

   INDEX OF DOCUMENTS:

   - Exhibit 2 - Description of the Parties' Plans for Electronic Health Records Systems

3. **Documents relating to health information exchanges (HIE) used by each party, including current usage, how information is shared, fees or costs paid to use the system, how many other providers (e.g., physicians, outpatient facilities, hospitals) currently use the system, how records are shared, the extent of patient records included in the exchange, and any consulting reports.**

   RESPONSE: A description of both Parties' use of health information exchanges ("HIEs") with information showing the current system used by each party, including current usage, how information is shared, fees or costs paid to use the system and the number of other providers currently using the system, how the records are shared, and the extent of patient records included in the exchange is attached as Exhibit 3. Wellmont's agreements with OnePartner will be submitted under CID to the Attorney General's Office. Wellmont does not have any consulting reports responsive to this request.

   INDEX OF DOCUMENTS:

   - Exhibit 3.1 - Description of the Parties' Use of Health Information Exchanges
   - Exhibit 3.2 - Wellmont's Agreements with OnePartner (considered confidential information and will be subsequently filed)

4. **Documents relating to any plans to create the Common Clinical IT platform, including any internal analyses and consultant reports.**

RESPONSE: If the COPA is approved, the Parties expect the New Health System to assess each party's existing electronic health records computer platform(s), including third party systems, hardware, software, computer infrastructure, etc., to determine the roadmap to bring the New Health System onto a Common Clinical IT Platform, as described in the Application. This assessment is expected to take at least six months after the New Health System is formed. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, a high-level timeline for implementation of the Common Clinical IT Platform is included as Exhibit 4 for reference. Wellmont does not have any consulting reports responsive to this request.

INDEX OF DOCUMENTS:

- Exhibit 4 - Timeline for Implementation of the Common Clinical IT Platform

5. **Documents relating to any culture audits, governance studies or audits conducted internally or externally, including the ultimate findings and any consultant reports.**

RESPONSE: These documents were submitted by Wellmont on June 16, 2016, pursuant to CID.

6. **Documents relating to how past physician acquisitions and physician contracts or affiliations have contributed to each party's ability to enter into risk based and/or value based contracts.**

RESPONSE: A list of the physician practices that were acquired by Wellmont over the last five (5) years is attached as Exhibit 6. The ability to successfully manage the cost-effective care of a patient population requires the broadest possible care continuum, including multiple specialty physicians, hospitals, outpatient centers, skilled nursing facilities, home health agencies, etc. Physician practice acquisitions are one way that Wellmont has improved its ability to enter into risk-based and/or value-based contracts. The physician practice acquisitions have enabled Wellmont to align resources and ensure adequacy of its provider networks. The Confidential Counsel Memoranda that was provided under CID by Wellmont on May 12, 2016 includes a list of all Wellmont contracts with employed and independent physicians (see Exhibit D - Legal Memoranda, Section 3.07 "Physician Agreements"). Copies of individual physician agreements will be provided upon request.

INDEX OF DOCUMENTS:

- Exhibit 6 - List of Physician Practices that were Acquired by Wellmont over the Last Five Years

7. **Documents relating to the party's current use of tele-medicine in the area as well as plans for future use, including any grant money obtained to develop or deploy any systems for utilizing tele-medicine.**

RESPONSE: The documents relating to Wellmont's current use of tele-medicine in the area and plans for future use will be submitted under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 7 - Documents Relating to Wellmont's Current Use of Tele-Medicine (considered confidential information and will be subsequently filed)

8. **Documents filed with the Health Services Development Agency within the past five (5) years.**

RESPONSE: In the last five (5) years, Wellmont has applied for, and received, the following Certificates of Need in Tennessee and Certificates of Public Need in Virginia:

County	Wellmont Entity	Description	CON/COPN Number
Sullivan County, Tennessee	Wellmont Cardiology Services, Inc.	Establishment of an ODC by acquisition of an existing cardia PET system now serving patients in Gray, TN; and to relocate the PET system and initiate cardiac PET services at the Wellmont CVA Heart Institute building	CN1304-013
Sullivan County, Tennessee	Bristol Regional Medical Center	The establishment of an outpatient diagnostic center initiating magnetic resonance imaging unit (MRI) and the acquisition of a stand-up MRI for neurological and spine applications. The center will be located across the street from the Medical Center.	CN0508-073
Washington County, Virginia	Wellmont Medical Associates, Inc. d/b/a Wellmont Urgent Care-Abingdon	Establish a Specialized Center for CT Imaging	COPN Request No. VA-7923

In addition, Wellmont requested a modification from the Tennessee Health Services Development Agency via letter for the following Certificate of Need which was unanimously approved at the Agency's April 27, 2016 meeting:

County	Wellmont Entity	Description	CON/COPN Number
Sullivan County, Tennessee	Bristol Regional Medical Center	Request to expand mobile PET service from 2 to 3 days per week	Modification to CN0005-034A

Wellmont has not contested any Certificates of Need in Tennessee or Certificates of Public Need in Virginia in the last five years.

9. **Documents relating to each party's accountable care organization (ACO) or shared savings arrangement, including whether the ACO or shared savings arrangement is hospital-led or physician led. Also for each physician, mid-level practitioner, or other health profession on whose behalf a party negotiates with health insurance plans or is reimbursed based on a health insurance plan's rate schedule with the party, or with whom a party has an affiliation or contractual, please provide the following information:**

   - **Name;**
   - **Medical specialties;**
   - **Current office practice address(es);**
   - **National provider identification (NPI) number and any other uniform physician identification number;**
   - **Employer and group NPI for that employer;**
   - **Whether he or she has an affiliation agreement with the party (e.g., IP A, ACO or any other affiliation or contractual arrangement) and the type of arrangement;**
   - **Date on which he or she was acquired, employed by, and/or affiliated with the merging party; and**
   - **The number of patients he or she treated each year.**

RESPONSE: Wellmont entered into an ACO agreement with CMS for the 2013-2015 cycles. This participation fit within Wellmont's plans to improve population health and bring value to its patients. However after year two of participation, Wellmont made the decision to cease participation in the program and Wellmont Integrated Network ("WIN") completed its last year of involvement in 2014, after year number two. WIN reported quality metrics in early 2015. Those metrics included patient experience score, preventive treatment criteria and chronic care standards.

Wellmont made the difficult decision to close its ACO early, because the costs incurred by continuation in the ACO program with no return were taking money away from Wellmont's Patient Centered Medical Home and Transitional Care Management programs. Wellmont viewed these two programs as very important to better managing patient's health.

Wellmont's ACO performance was varied during the system's participation in the CMS program. While readmission rates increased slightly, Wellmont's ability to get patients in to

see their primary care providers after discharge also increased. This meant Wellmont was following its Patient-Centered Medical home and Transitional Care Management program mandates for rapid follow-up status post discharge.

WIN also decreased discharge rates per 1,000 for the number of Ambulatory Care Sensitive conditions of COPD/Asthma, CHF and Bacterial pneumonia.

With regard to quality metrics, several of WIN's measures showed important increases. Those metrics that demonstrated an improvement of over 4 percent were:

- The percent of primary care providers who successfully attested for the EMR Incentive program (a Care Coordination/Patient Safety measure)
- Increased flu and pneumonia vaccines,
- Tobacco use screening and cessation intervention,
- Depression screening,
- Colorectal cancer screening,
- Blood pressure screening,
- Diabetic measures,
- The CAD composite measures, and
- Drug therapy for lowering LDL cholesterol.

WIN scored a composite quality score of 85% which enabled WIN to have a final sharing rate of 42.5% out of 50% of any potential shared savings. Unfortunately, however, WIN was not able to show a high enough savings rate on the 11,130 assigned beneficiaries to trip the shared savings trigger. In spite of this, WIN's cost per beneficiary was more than $1000 less than both the cost for beneficiary based upon the national average cost per beneficiary for traditional Medicare.

Wellmont continues to remain deeply committed to improving quality and patient experience while controlling cost as evidenced by its Patient Centered Medical Home and Transitional Care Management programs. While the CMS ACO program did not yield the financial results that Wellmont had hoped, Wellmont has used this experience as a learning opportunity to continue refining its approach to population health management.

The information related to each physician, mid-level practitioner, or other health profession on whose behalf a party negotiates with health insurance plans or is reimbursed based on a health insurance plan's rate schedule with the party, or with whom a party has an affiliation or contractual, will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 9 - List of Providers on whose behalf a Party Negotiates with Health Insurance Plans (considered confidential information and will be subsequently filed)

10. **Documents relating to the party's existing and future relationship with East Tennessee State University and any other college or university.**

RESPONSE: Attached as Exhibit 10 is a list of the current documents related to Wellmont's relationship with East Tennessee State University and all other colleges or universities. Copies of these agreements are available upon request.

INDEX OF DOCUMENTS:

- Exhibit 10 - List of Documents Relating to the Party's Existing and Future Relationship with East Tennessee State University and any other College or University

11. **Documents relating to the party's current relationship with East Tennessee Children's Hospital, including whether that relationship will continue under the proposed transaction and in what form, and if the relationship will terminate what specialties or services would be lost.**

RESPONSE: Attached as Exhibit 11 is a list of the current documents related to Wellmont's relationship with East Tennessee Children's Hospital. Copies of these documents are available upon request.

The Parties envision that the New Health System will maintain an effective and appropriate referring relationship with East Tennessee Children's Hospital, and many other children's hospitals nationally, to ensure that children in the proposed Geographic Service Area have access to all needed services - including highly specialized services that may be offered on a limited basis regionally or nationally. As a result, the Parties do not anticipate losing access to any specialties or services as a New Health System. The New Health System will have an explicit goal to develop access points for children's services throughout Northeast Tennessee and Southwest Virginia in order to expand the depth of specialty services for children in the proposed Geographic Service Area through the effective recruitment and retention of needed physicians.

INDEX OF DOCUMENTS:

- Exhibit 11 - List of Documents Relating to the Party's Current Relationship with East Tennessee Children's Hospital

12. **Documents/information relating to the hospital bed count for competing hospitals in the geographic region.**

RESPONSE: Attached as Exhibit 12 are the current hospital bed counts for competing hospitals in the geographic region.

INDEX OF DOCUMENTS:

- Exhibit 12 - Current Hospital Bed Counts for Competing Hospitals in the Geographic Region

13. Documents/information relating to volume outcomes, in particular, what specialties or sub-specialties do the parties intend to consolidate as part of the proposed transaction.

RESPONSE: Attached as Exhibit 13 are the current volume outcomes for Wellmont and Mountain States.

The New Health System intends to enact the clinical efficiencies set forth in the FTI Consulting report, which is referenced in the Application and provided to the Attorney General's Office under CID. While the efficiency numbers set forth in the FTI Report were established and validated by independent outside experts, it does not set forth details which have yet to be determined. The decisions on the impact to specific facilities or services within facilities will only be decided once the New Health System is formed and after significant study and assessment along with input from key stakeholders and physicians. This process will be guided by the Alignment Policy as set forth in the Application.

INDEX OF DOCUMENTS:

- Exhibit 13 - Current Volume Outcomes for Wellmont and Mountain States and Duplication of Services

14. Documents relating to current efforts regarding physician recruitment, including what difficulties the party has encountered and whether these difficulties will be alleviated or lessened as a result of the proposed transaction.

RESPONSE: Wellmont periodically commissions physician demand planning assessments utilizing outside resources. Wellmont is currently completing one such study that is being performed by 3d Health, Inc., and will be available in late June 2016. Preliminary results indicate significant gaps in existing supply and demand, which is further exacerbated by anticipated physician retirements for those over age 65.

In general, physician recruitment is very competitive for most specialties. Quality of life and cost of living are benefits that can be emphasized to candidates considering locating to the Geographic Service Area, but the overall health of the population and the low reimbursement/wage index present challenges, particularly with those considering independent private practice opportunities. In rural areas and community hospitals, the practice environment is particularly challenging for independent private practice resulting in the need for virtually all physicians to be employed by one of health systems, requiring a significant investment by the respective system.

The combination of the two health systems would create the financial capacity to subsidize needed physician recruitment and development of the medical staff. It would also create a

market that would support recruitment of specialty physicians that may not be able to sustain a practice if the market were divided. It would also create more diverse opportunities that are likely to appeal to certain candidates.

Documents related to Wellmont's physician recruitment efforts will be submitted under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 14 - Documents Related to Wellmont's Physician Recruitment Efforts (considered confidential information and will be subsequently filed)

15. Documents relating to the current duplication of services, including identification of those services that are currently being duplicated and that will be reduced or eliminated as a part of or due to the proposed transaction.

RESPONSE: Exhibit 15 shows the current duplication of services broken out by State. 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. The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually as outlined in the Application. The Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities as outlined in the FTI Consulting Report. As more fully discussed in Section 11.h.ii of the Application, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy which was submitted as Exhibit 11.13 to the Application. 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.

INDEX OF DOCUMENTS:

- Exhibit 15 - Current Duplication of Services

INDEX OF DOCUMENTS

Exhibit 2

Description of the Parties' Plans for Electronic Health Records Systems

See attached.

Exhibit 2

RESPONSE:

- ***Description of the Parties' Current Electronic Health Records Systems***

  - Wellmont currently uses Epic (2014 version) as its enterprise-wide electronic health record solution. It includes the enterprise system to support the workflows for all clinical areas (acute hospitals and outpatient centers), ambulatory clinics and urgent care centers, as well as the access and revenue system for financial and billing functions. This results in one record for each patient regardless of where they are seen within the Wellmont system.

  - Mountain States currently employs multiple Meaningful Use Stage 2 certified technologies to support health care services in the region.
    - The ambulatory space is based on the AllScripts Touchworks Electronic Health Record version 11.4.1 hf20 with a planned upgrade to 15.1 scheduled for August 2016. This system supports:

      - Problems, Allergy, Medication, and Immunization recoding and communication
      - Electronic Medication Prescribing (drug / allergy interaction checking)
      - Physician Order Entry
      - Physician documentation at point of care
      - Electronic lab and radiology resulting
      - Electronic document imaging
      - Intersystem Communication
      - Integrated patient portal supporting scheduling and clinical interaction
      - Patient Education

    - Additionally, Mountain States utilizes the Cerner Soarian Version 4.0.15 system for the acute setting. Major functions include:

      - Full integrated legal electronic health record
      - Problem, allergy, medication, and immunization capture and communication
      - Medication administration assurance
      - Clinician clinical documentation
      - Clinical order entry
      - Integration with clinical design and administration (IMRT, Critical Care)
      - Digital radiology capture and communication
      - Integrated lab result communication
      - Intersystem communication

The Acute and Ambulatory systems work as a cohesive unit, supporting all aspects of care across the continuum of the integrated healthcare delivery network.

- ***Description of the Parties' plan to convert to a single records system if the New Health System is approved***

  If the COPA is approved, the Parties expect the New Health System to assess each party's existing electronic health records computer platform(s), including third party systems, hardware, software, computer infrastructure, etc., to determine the roadmap to bring the New Health System onto a Common Clinical IT Platform, as described in the Application.

  This assessment is expected to take at least six months after the New Health System is formed. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, a high-level timeline for implementation of the Common Clinical IT Platform is included as Exhibit 4 for reference. Major categories for the implementation costs would include, but not be limited to, the following:

  - Hardware: New and Upgrades
  - Software: New and Upgrades
  - 3rd Party Systems and Interfaces
  - Licensing Fees
  - Vendor Implementation Fees
  - Consulting Fees
  - Labor Costs
  - Training/Training Related Materials
  - Go-Live Support
  - Post-Implementation Annual Maintenance Fees
  - Any Future Additions of EMR Applications

- ***Expected Benefits of the Common Clinical IT Platform.***

  The Common Clinical IT Platform that the New Health System adopts will allow providers in the New Health System to quickly obtain full access to patient records at the point of care and will be used for system-wide communication and monitoring of best practices and establishment of new protocols to improve quality of care. Specifically, the Common Clinical IT Platform is expected to result in a "One Patient-One Record" platform where all health information will be located on one system. The Parties intend for the Common Clinical IT Platform to include the following features:

  - Log inpatient visits, emergency department visits, outpatient visits, ambulatory clinic visits, urgent care visits, and any visit within the new system.

- When a physician views the patient record, they will be able to see ALL encounters that patient has had anywhere in the system. This will be available to both employed and non-employed physicians.
- The data will include all physician notes, nurses notes, therapy notes, all other clinical specialty notes, history/physical, discharge summaries, lab, radiology and other diagnostic reports, allergies, medications, problem lists, radiology images, photos of wounds and other physical notations as surgical photos, all physician orders placed, protocols used for treatment, patient data from other locations where the patient may have been treated, links to evidence based literature articles as reference and patient education materials.
- The physician will also be able to link out to past medical records of the patient in the previous EMR system, so they do not need to go back to another system to see the patient's history.
- Future appointments can be made as well as referrals to specialists.
- Follow up letters to referring physicians can be generated within the Common Clinical IT Platform and sent directly from the Common Clinical IT Platform.
- Results from outpatient testing will be delivered to the physician's in-basket to allow review of the results as soon as they are competed.
- Actual radiology/cardiology images can be viewed by the physician within the EMR without going to another system to see the image or to the Radiology Department to view.
- Patient results can be graphed or charted so trends can be viewed.
- Data reports can be generated to determine the quality of the care being delivered, which allows for peer review as required by accrediting agencies.
- Physicians can document the ICD-10 diagnoses with accompanying details for Meaningful Use purposes as required by CMS.
- Best practice alerts will notify the physician/clinical staff if the patient is at risk for certain issues, medication interactions, falls risk, and numerous other safety features.
- The order sets will include all orders that are required by CMS and other regulatory agencies as well as best practice guidelines to assure the patient is receiving the best and safest care.
- Physician notes can be dictated directly into the EMR, saving transcription and reporting time, so the notes are available immediately to any consulting physician or clinical staff.

The Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care. Additionally, the Platform will be used to facilitate the increased adoption of best practices and evidence-based medicine implemented by the New Health System. The New Health System intends to use the Common Clinical IT Platform to provide immediate system-wide alerts and new protocols to improve quality of care. This will enable the New Health System to reduce the

risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

- ***Expected Benefits of the Common Clinical IT Platform versus using the Health Information Exchange***.

  While the Common Clinical IT Platform will offer many benefits to patient care within the New Health System, not all providers in the region will be on the same platform as the New Health System and may not be able to share data with the New Health System. Historically, EHRs built by different vendors lacked transmission standards for exchanging patient data between healthcare entities. This meant that many EHR systems could not exchange data outside of their own private networks. The health information exchange ("HIE") is way of sharing electronic health information among doctors' offices, hospitals, labs, radiology centers, outpatient centers, and other health organizations. While the Common Clinical IT Platform is designed to facilitate the sharing of electronic health information across the New Health System, the HIE will allow the New Health System to share electronic health information with participating providers across the region and nation - regardless of their affiliation with the New Health System.

  The HIE that the New Health System has committed to will allow the doctors and nurses treating patients in a hospital or doctor's office to access the patient's medical history from any provider connected to the HIE. For example, an independent primary care doctor can review recent lab results whether the test was conducted at an independent specialist's office, at a New Health System hospital, or at third-party participating lab. Because all authorized doctors and medical personnel will see the same health information through the HIE, this will help to reduce any errors, avoid unneeded duplication of tests and procedures, and consequently, could reduce medical bills.

  A key distinction between the Common Clinical IT Platform and HIE is the information available to providers when accessing a medical record. While a provider on the Common Clinical IT Platform will be able to pull up the patient's entire medical history contained in the patient record, the information available within an HIE is typically limited to certain fields that are most commonly used or accessed by providers. This information is typically limited to the following fields:

  - Name
  - Demographics
  - Active Allergies
  - Current Medications
  - Problem List (Current Problems)
  - Problem List (Resolved Problems)
  - Recent Visits
  - Immunizations

- History (Medical and Surgical)
- History (Family)
- History (Social)
- Last Recorded Vital Signs
- Progress Notes
- Plan of Care
- Functional Status
- Recent Results
- Primary Care Physician
- Custodial/Source Organization

Because the HIE is primarily designed to share information across multiple EHR systems in small and large settings, not all of the Common Clinical IT Platform features are available to providers using the HIE. For example, the Common Clinical IT Platform is expected to include the following features that are not typically included in HIE capabilities:

- Helping providers more effectively diagnose patients, reduce medical errors, and provide safer care through evidence-based tools built into the Common Clinical IT Platform
- Improving patient and provider interaction and communication, as well as health care convenience, by enabling electronic communications between providers and patients (e.g. secure messaging)
- Enabling safer, more reliable prescribing by enabling electronic transmission of prescriptions from provider offices to pharmacies
- Helping promote legible, complete documentation and accurate, streamlined coding and billing
- Reducing costs through decreased paperwork, improved safety, reduced duplication of testing, and improved health
- Enabling providers to improve efficiency and meet their business goals, improve productivity and work-life balance.

As health care moves from fee-for-service to value-based care, the sharing of clinical data for outcomes and accountable care will be very important both within the New Health System and across various health care organizations. The New Health System believes that the significant financial investments it is making to adopt a Common Clinical IT Platform will bring significant benefits for all patients seeking care within the New Health System. The New Health System's commitment to meaningfully participate in an HIE ensures that the health care data collected within the New Health System will be accessible by all participating providers across the region and nation. These two commitments taken together have the potential to drastically improve the quality of care offered across the region.

Exhibit 3.1

Description of the Parties' Use of Health Information Exchanges

See attached.

Exhibit 3.1

RESPONSE:

- ***Description of the health information exchanges ("HIE") currently used by each party***

    - Wellmont
        - Wellmont plans to begin participating in the OnePartner HIE in northeast Tennessee in June, 2016.
        - The initial cost to set up the interface with OnePartner was $63,500.
        - There are annual fees of $9,800 for Wellmont to continue sending information to OnePartner.
        - The cost for each provider to be able to access the information in the HIE is $149 per physician per month.
        - As of July, 2016, Wellmont expects to have 10 collaborator agreements that will provide 10-15 rotating physicians with access to OnePartner.
        - The only patient information available within the HIE is the 18 data points identified below. The patient information can be viewed and printed when the provider is accessing the HIE.

    - Mountain States
        - Mountain States is currently an acute data contributor to OnePartner under a five year agreement set to expire on December 31, 2019.
        - As an acute data contributor, Mountain States provides the following information to OnePartner:
            - Demographics
            - Encounters
            - Labs
            - Diagnoses
            - Procedures and
            - Radiology.
        - Clinical documents are scheduled to go-live in July 2016. For acute hospitals the clinical documents will include history and physical, progress notes (SOAP), consults, procedure notes, and discharge summaries. For ambulatory surgery centers, the clinical documents will include office visit assessments, post- op visit notes, ER follow up notes, and prenatal visit notes.
        - Mountain States Medical Group is currently testing ambulatory data on-boarding with OnePartner and will be complete by the end of August 2016. Once on-board, Mountain States Medical Group is expected to provide Demographics, Encounters, Vitals, Labs, Diagnoses, Procedures, Problems, Allergies, Medications, Immunizations, Clinical Documents to OnePartner for all patients treated by the Group's 375 providers and mid-levels.
        - Mountain States' current financial commitment to OnePartner is $98,000.

- Initial setup cost to connect to OnePartner was $53,500. Mountain States pays $8,900 per year for five years for access to the OnePartner data.
- In addition to exchanging 11,432,731 data transactions with OnePartner, Mountain States has had a broad range of experiences with data sharing arrangements.
- Currently, other data sharing partners include:
  - State of Franklin Health Associates : 373,673 data transactions
  - Inpatients Consultants: 289,760 data transactions
  - Medical Practice Management: 162,384 data transactions
  - East Tennessee State University: 69,502 data transactions.
- Mountain States also currently send Immunization data, and is in final testing for exchanging Syndromic Surveillance data, to the state of Tennessee. In addition, Mountain States currently sends Immunization and Syndromic Surveillance data to the Virginia Connect HIE.
- Mountain States was a Veterans Administration proof of concept, pilot and demonstration partner in the development of the Direct Messaging platform and has recently undertaken initial conversations with the Veterans Administration for potential inclusion with their Virtual Lifetime Electronic Record (VLER) program.
- Finally, Mountain States is actively working with Tennessee's Healthcare Innovation Initiative to develop a community case management tool.

- ***Description of the OnePartner HIE***
  - OnePartner is a for-profit limited liability company owned by physicians in northeast Tennessee.
  - OnePartner is exclusively a physician Regional Health Information Exchange available to providers located in Northeast Tennessee and Southwest Virginia.
  - It is operationalized through the use of a product named dbMotion. dbMotion is a context aware computer application that when deployed and integrated with a OnePartner collaborator's EMR, provides access to the OnePartner patient record from the practicing physician's EMR workstation.
  - Access to OnePartner is available through an online portal: https://provider.onepartnerhie.com.
  - Before accessing the OnePartner HIE data, a participating entity must sign a collaborator agreement, meet the criteria in the agreement, pay a subscription fee of $150-200 per month per provider, and meet the minimum standards for participating providers. They must also sign a Business Associate Agreement and a Data Sharing Agreement.
  - The information fields available in the OnePartner HIE are limited to the following:
    - Name
    - Demographics
    - Active Allergies
    - Current Medications

    - Problem List (Current Problems)
    - Problem List (Resolved Problems)
    - Recent Visits
    - Immunizations
    - History (Medical and Surgical)
    - History (Family)
    - History (Social)
    - Last Recorded Vital Signs
    - Progress Notes
    - Plan of Care
    - Functional Status
    - Recent Results
    - PCP
    - Custodial/Source Organization

- These 18 components are sent to the HIE unless a patient affirmatively opts-out and requests that their information not be included.
- Once on the system, HIE data can be printed and can be brought into the participating entity's EMR only if they have certain computer capabilities on their end.
- According to OnePartner, over the last four years:
    - the number of providers providing data is currently greater than 1,000
    - the number of providers viewing data is approximately 400
    - there are 654,083 unique patients have been entered into the database.
- Based on information provided by OnePartner, the top contributing providers are Mountain States, Holston Medical Group, and State of Franklin Health Associates.
- Again, based on information provided by OnePartner, the top accessors of data are Holston Medical Group, State of Franklin Health Associates, and Qualuable Medical Professionals.

Exhibit 3.2

Wellmont's Agreements with OnePartner

To be provided pursuant to CID.

Exhibit 4

Timeline for Implementation of the Common Clinical IT Platform

See attached.

Exhibit 4

d. Common Clinical IT and Health Information Exchange	Year 1				Year 2				Year 3				Year 4				Year 5				Year 6				Year 7				Year 8				Year 9				Year 10			
Tenn. Comp. R. & Regs. 1200-38-01-02(2)(a)10	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
i. System Integration 18-24 months																																								
Assessment of Health Systems including vendor		X	X																																				
System Implementation with data conversion and 3rd party interfaces				X	X	X	X	X	X	X	X	X																												
Training all Users (employed & non-employed providers)									X	X	X	X																												
1. Behavioral Health Capability												X																												
EMR systems include: - Standardized screening questionnaires & assessment tools - Clear and consistent documentation protocols - Treatment plans, flowsheet & restraint documentation - Suicide intervention tools																																								
Integration and interoperability follows the standard for an integrated EMR, which is fully integrated and interoperable.																																								
EMR system will have future development for a behavioral health module																																								
2. Integration											X	X																												
Large EMRs interface with over fifty 3rd party vendors, linking records, integrating lab, medical, diagnostic, referral, and scheduling. Interfaces are inbound and outbound, to and from vendors, providers, government entities, etc.																																								
3. Migration of Historical Data										X	X	X																												
Historical data such as medications, allergies and problems lists are generally converted to the new system. The remaining historical data will be accessible through a link inside the EMR to an archiving system such as DataArk (used at Wellmont.)																																								
4. Training of New Users									X	X	X	X																												
All employed and non-employed providers are required to attend a minimum of 8 hours classroom training and pass a test to gain access to the EMR. Surgeons /proceduralists/specialists require additional training time. Training is specialty specific and includes a personalization lab.																																								
5. Patient Portal Access												X																												
5.1 Medications, allergies, problem list, immunization records, test results, visit/admission summaries, e-visits, billing information with the capability to pay online as well as patient engagement: such as clinical offerings to healthy behavior classes, research studies, patient education are available through a patient portal.																																								
5.2The patient portal also links to other vendor enabled health systems.																																								
5.3 Patients have access to reconciled health care data from different health systems.																																								
6. Collecting, Analyzing and Reporting Quality Outcomes													X																												
Data is sent monthly to various analytical companies including Crimson, Comparion and CMS providing statistical analysis for clinical cost, quality, and patient satisfaction for both system and non system providers.																																								
ii $150 Million Investment																																								
1. Common Clinical IT Platform - $148m * This initiative provides the platform for both the common clinical IT solution and connectivity for health information exchange, population health management and quality measurement reporting. This creates the connected community of hospitals and care givers, providing patients full access to their personal health record.		X	X	X	X	X	X	X	X	X	X	X	X																										
a. Health information exchange - Health information exchange plans include regional, domestic, and international capabilities.														X																										
b. Quality reporting capabilities														X																										

d. Common Clinical IT and Health Information Exchange	Year 1				Year 2				Year 3				Year 4				Year 5				Year 6				Year 7				Year 8				Year 9				Year 10			
Tenn. Comp. R. & Regs. 1200-38-01-02(2)(a)10	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
c. Population Health Management														X																										
d. Connectivity for non system providers (current state)														X																										
2. EHR solution for non-system providers $2m*					X																																			
*Cost for the Common Clinical IT Platform will include, but not limited to, the following:																																								
-Hardware: new and upgrades																																								
-Software: new and upgrades																																								
-3rd party interfaces																																								
-Licensing fees																																								
-Post implementation annual maintenance fees																																								
-Vendor implementation fees																																								
-Consulting fees																																								
-Labor																																								
-Training/training related materials																																								
-Go-live support																																								
iii Regional Health Information Exchange	X																																							
Wellmont's participation in OnePartner/HIE will be fully operable June 23, 2016. MSHA is currently participating in OnePartner. It is expected that the New Health System will meaningfully participate in a health information exchange.																																								

Exhibit 6

List of Physician Practices that were Acquired by Wellmont over the Last Five Years

See attached.

Exhibit 6

Wellmont Health System
Acquisition Summary
For the Fiscal Years Ended 06/30/2010 thru 06/30/2015
[Including 2016)

Acquisitions	Wellmont Entity Name	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY 2016
Cardiovascular Associates, PC	Wellmont Cardiology Services	May 2010						
Pulmonary Associates	Wellmont Medical Associates	June 2010						
Sleep Evaluation Center	Wellmont Medical Associates	June 2010						
Kingsport Bronchoscopy Center		June 2010						
HMG Sleep Labs	Wellmont Health Services		Oct 2010					
Tri-State Cardiology	Wellmont Cardiology Services			Oct 2011				
RHA Sulllivan	Wellmont Wexford House					12/2/2013		
Dr. Moloney, PC	Wellmont Medical Associates			12/30/2012				
Hope WC Center, PA	Wellmont Medical Associates			12/30/2012				
Blue Ridge Medical Specialist	Wellmont Health System		12/30/2011					
Appalachian Healthcare Assoc.	Wellmont Health System							5/31/2016
Appalachian After Hours Care, PC	Wellmont Health System							5/31/2016
Donald Anderson, MD/Cardiology Assoc of Wytheville PLLC	Wellmont Cardiology Services				5/5/2012			

Exhibit 7

Documents Relating to Wellmont's Current Use of Tele-Medicine

To be provided pursuant to CID.

Exhibit 9

List of Providers on whose behalf a Party Negotiates with Health Insurance Plans

To be submitted pursuant to CID.

Exhibit 10

List of Documents Relating to the Party's Existing and Future Relationship with East Tennessee State University and any other College or University

See attached.

Exhibit 10

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date
American College of Radiology	Holston Valley Medical Center	1007.280C	Type Undefined	7/30/2014	7/29/2017
American College of Surgeons	Holston Valley Medical Center	1007.1100C	Business Associate Agreement (Stand Alone)	5/15/2011	5/14/2017
Appalachian College of Pharmacy	Wellmont Health System - Corporate	1001.1648C	Affiliation Agreement	1/6/2015	1/5/2018
Bill Gatton College of Pharmacy	Wellmont Health System - Corporate	1001.691C	Affiliation Agreement	2/5/2015	3/5/2017
Bluefield College	Wellmont Health System - Corporate	1001.556C	Affiliation Agreement	11/8/2014	11/18/2017
Chamberlain College of Nursing	Wellmont Health Services	1015.112C	Affiliation Agreement	9/28/2015	9/27/2016
Chattanooga State Community College	Wellmont Health System - Corporate	1001.1159C	Affiliation Agreement	8/19/2013	8/18/2016
College of Public Health	Wellmont Health System - Corporate	1001.688C	Affiliation Agreement	2/11/2016	3/16/2019
Des Moines University-College of Osteopathic Medicine	Wellmont Health System - Corporate	1001.1485C	Affiliation Agreement	12/17/2013	7/12/2017
Emory and Henry College	Wellmont Health System - Corporate	1001.149C	Affiliation Agreement	12/14/2015	12/14/2016
Emory and Henry College	Wellmont Health System - Corporate	1001.271C	Affiliation Agreement	9/10/2014	9/9/2017
Hazard Community and Technical College	Wellmont Health System - Corporate	1001.193C	Affiliation Agreement	7/23/2014	7/22/2017
Hazard Community and Technical College/Southeast Kentucky Community and Technical College	Wellmont Health System - Corporate	1001.620C	Affiliation Agreement	2/5/2015	2/4/2017
James H Quillen College of Medicine	Wellmont Health System - Corporate	1001.1300C	Type Undefined	11/6/2013	11/5/2018
James H Quillen College of Medicine	Wellmont Health System - Corporate	1001.1301C	Type Undefined	2/8/2008	11/5/2018
Jefferson College of Health Services	Wellmont Health System - Corporate	1001.677C	Affiliation Agreement	2/4/2016	2/4/2019
Lake Erie College of Osteopathic Medicine	Wellmont Health System - Corporate	1001.702C	Affiliation Agreement	7/1/2011	6/30/2016
Mary Baldwin College	Wellmont Health System - Corporate	1001.538C	Affiliation Agreement	10/1/2014	10/1/2017
Milligan College	Wellmont Health System - Corporate	1001.1725C	Affiliation Agreement	4/12/2016	4/12/2017
Milligan College	Wellmont Health System - Corporate	1001.191C	Affiliation Agreement	7/28/2014	7/27/2017
Milligan College	Wellmont Health System - Corporate	1001.710C	Type Undefined	8/27/2007	Auto renews
Mountain Empire Community College	Wellmont Health System - Corporate	1001.1673C	Affiliation Agreement	12/15/2015	12/15/2016
Mountain Empire Community College	Wellmont Health System - Corporate	1001.467C	Affiliation Agreement	7/23/2015	7/22/2016

Exhibit 10

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date
Mountain Empire Community College	Wellmont Health System - Corporate	1001.561C	Affiliation Agreement	11/3/2014	11/2/2016
Mountain Empire Community College	Wellmont Health System - Corporate	1001.589C	Affiliation Agreement	11/1/2014	10/31/2017
National College of Business and Technology	Wellmont Health System - Corporate	1001.504C	Affiliation Agreement	10/14/2014	10/13/2017
Northeast State Community College	Wellmont Health System - Corporate	1001.152C	Affiliation Agreement	12/18/2015	12/17/2016
Northeast State Community College	Wellmont Health System - Corporate	1001.360C	Affiliation Agreement	7/1/2015	6/30/2016
Northeast State Community College	Wellmont Health System - Corporate	1001.361C	Affiliation Agreement	7/1/2015	7/1/2018
Northeast State Community College	Wellmont Health System - Corporate	1001.362C	Affiliation Agreement	3/31/2015	3/30/2017
Northeast State Community College	Wellmont Health System - Corporate	1001.621C	Affiliation Agreement	1/14/2015	1/13/2017
Northeast State Community College	Wellmont Health System - Corporate	1001.645C	Affiliation Agreement	3/31/2015	3/30/2017
Northeast State Community College	Wellmont Health System	1001.1816	Affiliation Agreement	4/19/2016	Auto renews
Philadelphia College of Osteopathic Medicine	Wellmont Health System - Corporate	1001.1601C	Affiliation Agreement	7/13/2015	7/12/2016
Presbyterian College	Holston Valley Medical Center	1007.1373C	Affiliation Agreement	6/28/2013	Auto renews
Rector and Visitors of the University of Virginia College at Wise	Wellmont Health System - Corporate	1001.560C	Affiliation Agreement	11/20/2014	11/19/2017
Simmons College	Wellmont Health System - Corporate	1001.1676C	Affiliation Agreement	12/21/2015	12/21/2016
South Carolina College of Pharmacy	Bristol Regional Medical Center	1002.1060C	Affiliation Agreement	8/6/2013	8/5/2016
South College	Wellmont Health System - Corporate	1001.315C	Affiliation Agreement	5/1/2015	4/30/2017
South College of Knoxville	Wellmont Medical Associates	1018.1674C	Affiliation Agreement	1/25/2016	1/25/2017
Southeast Kentucky Community and Technical College	Wellmont Health System - Corporate	1001.1006C	Affiliation Agreement	1/2/2016	1/31/2017
Southwest Virginia Community College	Wellmont Health System - Corporate	1001.1366C	Affiliation Agreement	8/6/2013	8/5/2016
Southwest Virginia Community College	Wellmont Health System - Corporate	1001.176C	Affiliation Agreement	6/1/2010	5/31/2017
Southwest Virginia Community College	Wellmont Health System - Corporate	1001.450C	Affiliation Agreement	6/17/2015	6/16/18
Southwest Virginia Community College	Wellmont Health System - Corporate	1001.451C	Affiliation Agreement	6/16/2015	6/15/18
Southwest Virginia Community College	Wellmont Health System - Corporate	1001.639C	Affiliation Agreement	6/1/2015	6/1/2017
Tennessee College of Applied Technology/Practical Nursing	Wellmont Health System - Corporate	1001.172C	Affiliation Agreement	6/17/2014	6/16/2017

Exhibit 10

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date
Tusculum College	Wellmont Health System - Corporate	1001.1005C	Affiliation Agreement	1/25/2016	1/24/2017
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER AT FORT WORTH on behalf of Its Texas College of Osteopathic Medicine	Wellmont Health System - Corporate	1001.322C	Affiliation Agreement	5/2/2013	5/1/2017
University of Pikeville - Kentucky College of Osteopathic Medicine	Wellmont Health System - Corporate	1001.266C	Affiliation Agreement	9/21/2014	9/21/2017
Volunteer State Community College	Wellmont Health System - Corporate	1001.96C	Affiliation Agreement	10/16/2015	10/15/2016
Walters State Community College	Wellmont Health System - Corporate	1001.1294C	Affiliation Agreement	4/1/2016	4/1/2019
Walters State Community College	Wellmont Health System - Corporate	1001.1691C	Affiliation Agreement	12/7/2015	12/7/2018
Western University of Health Sciences College of Osteopathic Medicine of the Pacific	Wellmont Health System - Corporate	1001.623C	Affiliation Agreement	2/18/2015	2/17/2017
Wytheville Community College	Wellmont Health System - Corporate	1001.181C	Affiliation Agreement	6/1/2010	5/31/2017
Wytheville Community College	Wellmont Health System - Corporate	1001.1677C	Affiliation Agreement	6/1/2015	6/1/2017
Bellarmine University	Wellmont Health System - Corporate	1001.192C	Affiliation Agreement	7/1/2014	7/1/2017
Bill Gatton College of Pharmacy	Wellmont Health System - Corporate	1001.691C	Affiliation Agreement	2/5/2015	3/5/2017
College of Public Health	Wellmont Health System - Corporate	1001.688C	Affiliation Agreement	2/11/2016	3/16/2019
Des Moines University-College of Osteopathic Medicine	Wellmont Health System - Corporate	1001.1485C	Affiliation Agreement	12/17/2013	7/12/2017
King University Nursing Program	Wellmont Health System - Corporate	1001.318C	Affiliation Agreement	8/1/2014	7/31/2017
Kingsport Family Medicine Residency	Wellmont Cardiology Services	1013.1240C	Letter of Agreement	7/1/2012	6/30/2017
Kingsport Family Medicine Residency	Wellmont Cardiology Services	1013.1251C	Letter of Agreement	7/1/2012	6/30/2017
Lincoln Memorial University	Wellmont Health System - Corporate	1001.1222C	Affiliation Agreement	1/30/2016	1/29/2019
Lincoln Memorial University	Wellmont Health System - Corporate	1001.712C	Affiliation Agreement	1/30/2016	1/30/2017
Lincoln Memorial University Medical Clinic	Wellmont Health System - Corporate	1001.241C	Affiliation Agreement	7/1/2014	Auto renews
Nova Southeastern University, Inc dba Nova Southeastern University	Wellmont Health System - Corporate	1001.178C	Affiliation Agreement	5/12/2015	5/11/2017
Novadaq Corp	Entity Undefined	1021.748C	Consulting Services Agreement	8/9/2010	Auto renews
Radford University	Wellmont Health System - Corporate	1001.139C	Affiliation Agreement	12/2/2015	12/1/2016

Exhibit 10

Vendor (Other Party)	Contracting Entity	Contract No.	Contract Type	Effective Date	Expiration Date
Radford University	Wellmont Health System - Corporate	1001.636C	Affiliation Agreement	3/23/2015	3/22/2017
Shenandoah University	Wellmont Health System - Corporate	1001.539C	Affiliation Agreement	10/13/2014	11/19/2017
University of North Texas	Wellmont Health System - Corporate	1001.652C	Affiliation Agreement	5/2/2014	5/1/2017
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER AT FORT WORTH on behalf of Its Texas College of Osteopathic Medicine	Wellmont Health System - Corporate	1001.322C	Affiliation Agreement	5/2/2013	5/1/2017
University of Pikeville - Kentucky College of Osteopathic Medicine	Wellmont Health System - Corporate	1001.266C	Affiliation Agreement	9/21/2014	9/21/2017
University of Tennesse at Chattanooga	Wellmont Health System - Corporate	1001.1642C	Affiliation Agreement	7/1/2014	6/30/2017
University of Tennessee	Wellmont Health System - Corporate	1001.1729C	Affiliation Agreement	4/25/2016	4/25/2017
University of Tennessee Health Science Center	Wellmont Health System - Corporate	1001.590C	Affiliation Agreement	1/1/2015	12/31/2016
University of Tennessee Memorial Hospital	Hawkins County Memorial Hospital	1005.558C	Services Agreement	8/28/2014	8/27/2016
Vanderbilt University	Wellmont Health System - Corporate	1001.1597C	Affiliation Agreement	12/9/2013	12/8/2016
Vanderbilt University	Wellmont Health System - Corporate	1001.498C	Letter of Agreement	8/1/2015	3/31/2018
Vanderbilt University	Wellmont Health System - Corporate	1001.546C	Confidentiality & Non-Disclosure Agreements	11/17/2014	11/16/2016
Vanderbilt University	Wellmont Health System - Corporate	1001.628C	Services Agreement	2/1/2015	1/31/2018
Virginia Commonwealth University	Wellmont Health System - Corporate	1001.1652C	Affiliation Agreement	6/1/2014	5/31/2017
Virginia Commonwealth University	Wellmont Health System - Corporate	1001.1723C	Affiliation Agreement	4/2/2016	4/2/2017
Virginia Commonwealth University	Wellmont Health System - Corporate	1001.23C	Affiliation Agreement	6/15/2015	6/14/2018
Walden University	Wellmont Medical Associates	1018.1367C	Affiliation Agreement	7/23/2013	7/22/2016
Western Carolina University	Wellmont Health System - Corporate	1001.684C	Affiliation Agreement	4/1/2016	5/1/2017
Western University of Health Sciences College of Osteopathic Medicine of the Pacific	Wellmont Health System - Corporate	1001.623C	Affiliation Agreement	2/18/2015	2/17/2017

Exhibit 11

List of Documents Relating to the Party's Current Relationship with East Tennessee Children's Hospital

See attached.

Exhibit 11

Agreement Title	Wellmont Contracting Party	Other Contracting Party (Parties)	Effective Date
Leased Employee Agreement	Wellmont Health System d/b/a Wellmont Holston Valley Medical Center	East Tennessee Children's Hospital	1/1/2016
Pediatric Specialist Agreement	Wellmont Health System d/b/a Wellmont Holston Valley Medical Center	East Tennessee Children's Hospital	9/14/2016
Tennessee Emergency Medical Services for Children Model Interfacility Pediatric Transfer Agreement	Wellmont Hawkins County Hospital	East Tennessee Children's Hospital Association, Inc.	4/24/2014
Tennessee Emergency Medical Services for Children Interfacility Pediatric Education/Resource Agreement	Wellmont Hawkins County Hospital	East Tennessee Children's Hospital	4/24/2014
Tennessee Emergency Medical Services for Children Model Interfacility Pediatric Transfer Agreement	Wellmont Hancock County Hospital	East Tennessee Children's Hospital Association, Inc.	4/24/2014
Tennessee Emergency Medical Services for Children Interfacility Pediatric Education/Resource Agreement	Wellmont Hancock County Hospital	East Tennessee Children's Hospital Association, Inc.	4/24/2014
Wellmont Patient Transfer Agreement	Wellmont Health System d/b/a Bristol Regional Medical Center	East Tennessee Children's Hospital Association, Inc.	2/1/2011

Exhibit 12

Current Hospital Bed Counts for Competing Hospitals in the Geographic Region

See attached.

Exhibit 12

Hospital	SYSTEM AFFILIATION	COUNTY	Staffed Beds	Licensed Beds	Staffed Beds Occupancy	Licensed Beds Occupancy	Average Daily Census
Wellmont Lonesome Pine Hospital	Wellmont	Wise, VA	21	60	49.9%	17.5%	10.5
Mountain View Regional Medical Center (a)	Wellmont	Norton City/Wise,VA	18	74	64.7%	15.7%	11.7
Wellmont Bristol Regional Medical Center	Wellmont	Sullivan, TN	261	312	44.5%	37.3%	116
Wellmont Holston Valley Medical Center	Wellmont	Sullivan, TN	375	505	57.5%	42.7%	216
Wellmont Hancock County Hospital	Wellmont	Hancock, TN	10	10	29.9%	29.9%	3.0
Wellmont Hawkins County Memorial Hospital	Wellmont	Hawkins, TN	46	50	17.6%	16.1%	8.1
Dickenson Community Hospital	Mountain States	Dickenson, VA	2	25	1.9%	0.2%	0.0
Johnson County Community Hospital	Mountain States	Johnson, TN	2	2	4.8%	4.8%	0.1
Quillen Rehabilitation Hospital	Mountain States	Washington, TN	26	26	73.5%	73.5%	19
Unicoi County Memorial Hospital, Inc.	Mountain States	Unicoi, TN	13	48	85.6%	23.2%	11.1
Smyth County Community Hospital	Mountain States	Smyth, VA	44	44	44.2%	44.2%	19
Russell County Medical Center	Mountain States	Russell, VA	50	78	54.8%	35.1%	27
Norton Community Hospital (a)	Mountain States	Norton City/Wise,VA	57	129	57.8%	25.6%	33
Sycamore Shoals Hospital	Mountain States	Carter, TN	74	121	55.6%	34.0%	41
Woodridge Psychiatric Hospital	Mountain States	Washington, TN	84	84	76.4%	76.4%	64
Franklin Woods Community Hospital	Mountain States	Washington, TN	80	80	52.0%	52.0%	42
Indian Path Medical Center	Mountain States	Sullivan, TN	160	239	41.4%	27.7%	66
Johnston Memorial Hospital (a)	Mountain States	Washington, VA	112	116	103.6%	100.0%	116
Johnson City Medical Center	Mountain States	Washington, TN	501	491	65.4%	66.7%	328
Buchanan General Hospital	Other	Buchanan, VA	49	134	29.3%	10.7%	14
Carilion Tazewell Community Hospital	Other	Tazewell, VA	7	56	84.1%	10.5%	5.9
Clinch Valley Medical Center (a)	Other	Tazewell, VA	97	161	44.2%	26.6%	43
Takoma Regional Hospital	Other	Greene, TN	33	100	95.8%	31.6%	32
Tennova Healthcare-Lakeway Regional Hospital	Other	Hamblen, TN	65	135	55.2%	26.6%	36
Tennova Healthcare-Newport Medical Center	Other	Cocke, TN	36	74	59.0%	28.7%	21
Wythe County Community Hospital (a)	Other	Wythe, VA	20	92	92.8%	20.2%	19
Laughlin Memorial Hospital	Other	Greene, TN	140	140	25.7%	25.7%	36
Morristown-Hamblen Healthcare System	Other	Hamblen, TN	131	167	54.4%	42.7%	71

(a) Excluded Infant care stations from staffed beds where applicable for Virginia facilities

Sources

Tennessee Joint Annual Reports

Virginia ALSD Reports

Exhibit 13

Current Volume Outcomes for Wellmont and Mountain States and Duplication of Services

See attached.

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume								
			Product Line					
Tennessee Hospital County	Hospital Name	System	Cardiac Surgery	Cardiology	Cardiology Intervention	Endocrinology	ENT Surgery	Gastroenterology
Carter, TN	Sycamore Shoals Hospital	MSHA		281	6	153		341
Greene, TN	Laughlin Memorial Hospital, Inc.	All Other		249	41	96		321
	Takoma Regional Hospital	All Other		156	1	47		195
Hamblen, TN	Morristown-Hamblen Healthcare System	All Other		278	89	108		357
Hancock, TN	Wellmont Hancock County Hospital	Wellmont		21		7		11
Hawkins, TN	Wellmont Hawkins County Memorial Hospital	Wellmont		114		20		56
Johnson, TN	Johnson County Community Hospital	MSHA		1				1
Sullivan, TN	HealthSouth Rehabilitation Hospital-Kingsport	All Other						
	Indian Path Medical Center	MSHA	1	464	217	136		423
	Wellmont Bristol Regional Medical Center	Wellmont	231	844	257	270	11	974
	Wellmont Holston Valley Medical Center	Wellmont	263	1,196	683	328	19	982
Unicoi, TN	Unicoi County Memorial Hospital, Inc.	MSHA		51		16		79
Washington, TN	Franklin Woods Community Hospital	MSHA		240	4	137	9	479
	HealthSouth Quillen Rehabilitation Hospital	MSHA						
	Johnson City Medical Center	MSHA	273	2,050	1,203	479	14	1,489
	Woodridge Psychiatric Hospital	MSHA		1				1
Grand Total			768	5,946	2,501	1,797	53	5,709
Lakeway data from 2014								
Hospital Name	Cardiac Surgery			Cardiology	Cardiology Intervention	Endocrinology	ENT Surgery	Gastroenterology
Tennova Healthcare-Lakeway Regional Hospital				184	3	62		247
Grand Total				184	3	62		247
			Product Line					
Virginia Hospital County	Hospital Name	System		Cardiology	Cardiology Intervention	Endocrinology	ENT Surgery	Gastroenterology
Buchanan, VA	Buchanan General Hospital	All Other		88		29		58
Dickenson, VA	Dickenson Community Hospital	MSHA		1				1
Russell, VA	Russell County Medical Center	MSHA		119		67		102
Smyth, VA	Smyth County Community Hospital	MSHA		167		68		104
Tazewell, VA	Carilion Tazewell Community Hospital	All Other		68		16		34
	Clinch Valley Medical Center	All Other		377	66	151	1	390
Washington, VA	Johnston Memorial Hospital	MSHA		627	150	223	4	817
	Wellmont BRMC Ridgeview Pavilion	Wellmont						
Wise, VA	Norton Community Hospital	MSHA		242		117		259
	Wellmont LPH/MVRMC	Wellmont		219		65	3	138
Wythe, VA	Wythe County Community Hospital	All Other		135		20		96
Grand Total				2,043	216	756	8	1,999

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients residing within the 21 county service area only.

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume								
Tennessee Hospital County	**Hospital Name**	**System**	**General Medicine**	**General Surgery**	**Gynecology**	**Hematology**	**Neonatology**	**Nephrology**
Carter, TN	**Sycamore Shoals Hospital**	MSHA	404	151	13	46		272
Greene, TN	**Laughlin Memorial Hospital, Inc.**	All Other	228	182	6	32	67	126
	Takoma Regional Hospital	All Other	286	115	14	25	78	53
Hamblen, TN	**Morristown-Hamblen Healthcare System**	All Other	394	135	25	32	161	201
Hancock, TN	**Wellmont Hancock County Hospital**	Wellmont	28		1	1		21
Hawkins, TN	**Wellmont Hawkins County Memorial Hospital**	Wellmont	146	18		13		59
Johnson, TN	**Johnson County Community Hospital**	MSHA	3					3
Sullivan, TN	**HealthSouth Rehabilitation Hospital-Kingsport**	All Other		2				
	Indian Path Medical Center	MSHA	722	293	26	40	194	234
	Wellmont Bristol Regional Medical Center	Wellmont	733	677	56	112	214	504
	Wellmont Holston Valley Medical Center	Wellmont	1,048	851	141	165	207	544
Unicoi, TN	**Unicoi County Memorial Hospital, Inc.**	MSHA	82	19	1	9		49
Washington, TN	**Franklin Woods Community Hospital**	MSHA	457	356	30	34	338	260
	HealthSouth Quillen Rehabilitation Hospital	MSHA						
	Johnson City Medical Center	MSHA	1,965	1,173	123	242	755	842
	Woodridge Psychiatric Hospital	MSHA	2		1			
Grand Total			**6,498**	**3,972**	**437**	**751**	**2,014**	**3,168**
Lakeway data from 2014								
Hospital Name	**Cardiac Surgery**		**General Medicine**	**General Surgery**	**Gynecology**	**Hematology**	**Neonatology**	**Nephrology**
Tennova Healthcare-Lakeway Regional Hospital			123	68	15	34	19	153
Grand Total			**123**	**68**	**15**	**34**	**19**	**153**
Virginia Hospital County	**Hospital Name**	**System**	**General Medicine**	**General Surgery**	**Gynecology**	**Hematology**	**Neonatology**	**Nephrology**
Buchanan, VA	**Buchanan General Hospital**	All Other	71	16		5	1	68
Dickenson, VA	**Dickenson Community Hospital**	MSHA	2					2
Russell, VA	**Russell County Medical Center**	MSHA	156	2	1	10		94
Smyth, VA	**Smyth County Community Hospital**	MSHA	230	37	18	22		99
Tazewell, VA	**Carilion Tazewell Community Hospital**	All Other	71			2		46
	Clinch Valley Medical Center	All Other	267	143	60	50	45	188
Washington, VA	**Johnston Memorial Hospital**	MSHA	1,237	379	52	88	165	485
	Wellmont BRMC Ridgeview Pavilion	Wellmont	1					
Wise, VA	**Norton Community Hospital**	MSHA	567	139	16	30	47	144
	Wellmont LPH/MVRMC	Wellmont	280	90	20	17	48	109
Wythe, VA	**Wythe County Community Hospital**	All Other	196	50	39	11	57	55
Grand Total			**3,078**	**856**	**206**	**235**	**363**	**1,290**

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients residing within the 21 county service area only.

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume								
Tennessee Hospital County	**Hospital Name**	**System**	**Neurology**	**Neurosurgery**	**OB Deliveries Sections**	**OB Deliveries Vaginal**	**OB Other**	**Oncology Medicine**
Carter, TN	**Sycamore Shoals Hospital**	MSHA	112	1			2	30
Greene, TN	**Laughlin Memorial Hospital, Inc.**	All Other	62	2	42	94	6	27
	Takoma Regional Hospital	All Other	68	1	53	138	5	7
Hamblen, TN	**Morristown-Hamblen Healthcare System**	All Other	190	5	136	394	20	23
Hancock, TN	**Wellmont Hancock County Hospital**	Wellmont	5					1
Hawkins, TN	**Wellmont Hawkins County Memorial Hospital**	Wellmont	28					2
Johnson, TN	**Johnson County Community Hospital**	MSHA						
Sullivan, TN	**HealthSouth Rehabilitation Hospital-Kingsport**	All Other	2					
	Indian Path Medical Center	MSHA	174	81	216	358	21	27
	Wellmont Bristol Regional Medical Center	Wellmont	622	339	222	427	45	114
	Wellmont Holston Valley Medical Center	Wellmont	610	284	268	462	45	130
Unicoi, TN	**Unicoi County Memorial Hospital, Inc.**	MSHA	23				1	6
Washington, TN	**Franklin Woods Community Hospital**	MSHA	82	2	326	562	21	39
	HealthSouth Quillen Rehabilitation Hospital	MSHA	1					1
	Johnson City Medical Center	MSHA	1,138	529	330	740	179	331
	Woodridge Psychiatric Hospital	MSHA	28					
Grand Total			**3,145**	**1,244**	**1,593**	**3,175**	**345**	**738**

Lakeway data from 2014								
Hospital Name	**Cardiac Surgery**		**Neurology**	**Neurosurgery**	**OB Deliveries Sections**	**OB Deliveries Vaginal**	**OB Other**	**Oncology Medicine**
Tennova Healthcare-Lakeway Regional Hospital			75	40	25	53	1	24
Grand Total			**75**	**40**	**25**	**53**	**1**	**24**

Virginia Hospital County	**Hospital Name**	**System**	**Neurology**	**Neurosurgery**	**OB Deliveries Sections**	**OB Deliveries Vaginal**	**OB Other**	**Oncology Medicine**
Buchanan, VA	**Buchanan General Hospital**	All Other	3					2
Dickenson, VA	**Dickenson Community Hospital**	MSHA						
Russell, VA	**Russell County Medical Center**	MSHA	29					5
Smyth, VA	**Smyth County Community Hospital**	MSHA	43				3	11
Tazewell, VA	**Carilion Tazewell Community Hospital**	All Other	11					
	Clinch Valley Medical Center	All Other	104	3	82	146	18	78
Washington, VA	**Johnston Memorial Hospital**	MSHA	300	5	162	378	33	58
	Wellmont BRMC Ridgeview Pavilion	Wellmont	1				2	
Wise, VA	**Norton Community Hospital**	MSHA	126		54	83	26	11
	Wellmont LPH/MVRMC	Wellmont	36		105	128	28	10
Wythe, VA	**Wythe County Community Hospital**	All Other	46		87	98	10	6
Grand Total			**699**	**8**	**490**	**833**	**120**	**181**

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients residing within the 21 county service area only.

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume								
Tennessee Hospital County	**Hospital Name**	**System**	**Oncology Surgery**	**Ophthalmic Medicine**	**Ophthalmic Surgery**	**Oral Surgery**	**Orthopedic Medicine**	**Orthopedic Surgery**
Carter, TN	**Sycamore Shoals Hospital**	MSHA	8	3		2	28	97
Greene, TN	**Laughlin Memorial Hospital, Inc.**	All Other	4	2	2	2	27	142
	Takoma Regional Hospital	All Other	3	1			13	68
Hamblen, TN	**Morristown-Hamblen Healthcare System**	All Other	15			2	21	244
Hancock, TN	**Wellmont Hancock County Hospital**	Wellmont					4	
Hawkins, TN	**Wellmont Hawkins County Memorial Hospital**	Wellmont				1	8	
Johnson, TN	**Johnson County Community Hospital**	MSHA						
Sullivan, TN	**HealthSouth Rehabilitation Hospital-Kingsport**	All Other					1	
	Indian Path Medical Center	MSHA	9	1		2	25	337
	Wellmont Bristol Regional Medical Center	Wellmont	49	3	1	12	152	740
	Wellmont Holston Valley Medical Center	Wellmont	73			15	161	1,145
Unicoi, TN	**Unicoi County Memorial Hospital, Inc.**	MSHA	2				16	5
Washington, TN	**Franklin Woods Community Hospital**	MSHA	46	4		11	35	1
	HealthSouth Quillen Rehabilitation Hospital	MSHA						
	Johnson City Medical Center	MSHA	59	24	3	30	403	1,364
	Woodridge Psychiatric Hospital	MSHA						
Grand Total			**268**	**38**	**6**	**77**	**894**	**4,143**
Lakeway data from 2014								
Hospital Name	**Cardiac Surgery**		**Oncology Surgery**	**Ophthalmic Medicine**	**Ophthalmic Surgery**	**Oral Surgery**	**Orthopedic Medicine**	**Orthopedic Surgery**
Tennova Healthcare-Lakeway Regional Hospital			7	2			22	125
Grand Total			**7**	**2**			**22**	**125**
Virginia Hospital County	**Hospital Name**	**System**	**Oncology Surgery**	**Ophthalmic Medicine**	**Ophthalmic Surgery**	**Oral Surgery**	**Orthopedic Medicine**	**Orthopedic Surgery**
Buchanan, VA	**Buchanan General Hospital**	All Other	1				5	
Dickenson, VA	**Dickenson Community Hospital**	MSHA						
Russell, VA	**Russell County Medical Center**	MSHA				1	10	
Smyth, VA	**Smyth County Community Hospital**	MSHA	10			2	17	77
Tazewell, VA	**Carilion Tazewell Community Hospital**	All Other					4	
	Clinch Valley Medical Center	All Other	10	2		6	58	67
Washington, VA	**Johnston Memorial Hospital**	MSHA	17	5	1	9	87	323
	Wellmont BRMC Ridgeview Pavilion	Wellmont					1	
Wise, VA	**Norton Community Hospital**	MSHA	14	1		1	16	32
	Wellmont LPH/MVRMC	Wellmont	2	1		1	6	25
Wythe, VA	**Wythe County Community Hospital**	All Other	3	1		1	10	113
Grand Total			**57**	**10**	**1**	**21**	**214**	**637**

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients residing within the 21 county service area only.

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume								
Tennessee Hospital County	**Hospital Name**	**System**	**Otolaryngology**	**Plastic Surgery**	**Psychiatry**	**Pulmonary**	**Rehabilitation**	**Rheumatology**
Carter, TN	**Sycamore Shoals Hospital**	MSHA	10	9	154	663		8
Greene, TN	**Laughlin Memorial Hospital, Inc.**	All Other	23	4	4	561		5
	Takoma Regional Hospital	All Other	6		140	238	68	1
Hamblen, TN	**Morristown-Hamblen Healthcare System**	All Other	6	6	112	631		8
Hancock, TN	**Wellmont Hancock County Hospital**	Wellmont	1			57	4	2
Hawkins, TN	**Wellmont Hawkins County Memorial Hospital**	Wellmont	4	2	2	185	26	1
Johnson, TN	**Johnson County Community Hospital**	MSHA				9		1
Sullivan, TN	**HealthSouth Rehabilitation Hospital-Kingsport**	All Other					587	
	Indian Path Medical Center	MSHA	12	4	7	549		16
	Wellmont Bristol Regional Medical Center	Wellmont	26	25	820	1,291	1	25
	Wellmont Holston Valley Medical Center	Wellmont	31	26	19	1,534		45
Unicoi, TN	**Unicoi County Memorial Hospital, Inc.**	MSHA	1	1		114		
Washington, TN	**Franklin Woods Community Hospital**	MSHA	46	1	3	572		16
	HealthSouth Quillen Rehabilitation Hospital	MSHA					420	
	Johnson City Medical Center	MSHA	94	18	92	2,086	1	118
	Woodridge Psychiatric Hospital	MSHA			3,385			
Grand Total			**260**	**96**	**4,738**	**8,490**	**1,107**	**246**

Lakeway data from 2014								
Hospital Name	**Cardiac Surgery**		**Otolaryngology**	**Plastic Surgery**		**Pulmonary**		**Rheumatology**
Tennova Healthcare-Lakeway Regional Hospital			7	4		368		7
Grand Total			**7**	**4**		**368**		**7**

Virginia Hospital County	**Hospital Name**	**System**	**Otolaryngology**	**Plastic Surgery**	**Psychiatry**	**Pulmonary**	**Rehabilitation**	**Rheumatology**
Buchanan, VA	**Buchanan General Hospital**	All Other	15	2		345		2
Dickenson, VA	**Dickenson Community Hospital**	MSHA			6			
Russell, VA	**Russell County Medical Center**	MSHA	7		478	312	2	2
Smyth, VA	**Smyth County Community Hospital**	MSHA	1		8	275	164	2
Tazewell, VA	**Carilion Tazewell Community Hospital**	All Other	1		1	122		2
	Clinch Valley Medical Center	All Other	16	6	11	679		8
Washington, VA	**Johnston Memorial Hospital**	MSHA	29	22	16	939		19
	Wellmont BRMC Ridgeview Pavilion	Wellmont			599			
Wise, VA	**Norton Community Hospital**	MSHA	16	5	6	425	47	8
	Wellmont LPH/MVRMC	Wellmont	10	4	1	348	89	4
Wythe, VA	**Wythe County Community Hospital**	All Other	6	6	3	190	85	4
Grand Total			**101**	**45**	**1,129**	**3,635**	**387**	**51**

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients residing within the 21 county service area only.

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume								
Tennessee Hospital County	Hospital Name	System	Substance Abuse	Thoracic Surgery	Trauma Medical	Unspecified	Urology Medicine	Urology Surgery
Carter, TN	Sycamore Shoals Hospital	MSHA	13	1	4		4	1
Greene, TN	Laughlin Memorial Hospital, Inc.	All Other	3	1	6	1	8	8
	Takoma Regional Hospital	All Other	7	2	7			
Hamblen, TN	Morristown-Hamblen Healthcare System	All Other	17	5	8		17	26
Hancock, TN	Wellmont Hancock County Hospital	Wellmont			1		1	
Hawkins, TN	Wellmont Hawkins County Memorial Hospital	Wellmont	1	1				
Johnson, TN	Johnson County Community Hospital	MSHA						
Sullivan, TN	HealthSouth Rehabilitation Hospital-Kingsport	All Other						
	Indian Path Medical Center	MSHA	11	28	7		5	34
	Wellmont Bristol Regional Medical Center	Wellmont	43	57	42	50	45	84
	Wellmont Holston Valley Medical Center	Wellmont	26	106	48	20	29	70
Unicoi, TN	Unicoi County Memorial Hospital, Inc.	MSHA	3	1	1	1	2	
Washington, TN	Franklin Woods Community Hospital	MSHA	26	3	3		104	170
	HealthSouth Quillen Rehabilitation Hospital	MSHA						
	Johnson City Medical Center	MSHA	139	156	122		50	92
	Woodridge Psychiatric Hospital	MSHA	106					
Grand Total			395	361	249	72	265	485
Lakeway data from 2014								
Hospital Name	Cardiac Surgery			Thoracic Surgery	Trauma Medical	Unspecified	Urology Medicine	Urology Surgery
Tennova Healthcare-Lakeway Regional Hospital					7		9	27
Grand Total					7		9	27
Virginia Hospital County	Hospital Name	System	Substance Abuse	Thoracic Surgery	Trauma Medical	Unspecified	Urology Medicine	Urology Surgery
Buchanan, VA	Buchanan General Hospital	All Other	2		1			
Dickenson, VA	Dickenson Community Hospital	MSHA						
Russell, VA	Russell County Medical Center	MSHA	5		2		4	
Smyth, VA	Smyth County Community Hospital	MSHA	4		1		3	2
Tazewell, VA	Carilion Tazewell Community Hospital	All Other	3		1		2	
	Clinch Valley Medical Center	All Other	10	10	8		11	21
Washington, VA	Johnston Memorial Hospital	MSHA	34	22	14	1	31	30
	Wellmont BRMC Ridgeview Pavilion	Wellmont	16					
Wise, VA	Norton Community Hospital	MSHA	16	1	6		25	20
	Wellmont LPH/MVRMC	Wellmont	5	1	1	2	2	1
Wythe, VA	Wythe County Community Hospital	All Other	5	1	5		1	
Grand Total			100	35	39	3	79	74

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients residing within the 21 county service area only.

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume				
Tennessee Hospital County	Hospital Name	System	Vascular Surgery	Womens Other
Carter, TN	Sycamore Shoals Hospital	MSHA		5
Greene, TN	Laughlin Memorial Hospital, Inc.	All Other	43	
	Takoma Regional Hospital	All Other	15	
Hamblen, TN	Morristown-Hamblen Healthcare System	All Other	18	
Hancock, TN	Wellmont Hancock County Hospital	Wellmont		
Hawkins, TN	Wellmont Hawkins County Memorial Hospital	Wellmont		
Johnson, TN	Johnson County Community Hospital	MSHA		
Sullivan, TN	HealthSouth Rehabilitation Hospital-Kingsport	All Other		
	Indian Path Medical Center	MSHA	11	2
	Wellmont Bristol Regional Medical Center	Wellmont	131	1
	Wellmont Holston Valley Medical Center	Wellmont	257	3
Unicoi, TN	Unicoi County Memorial Hospital, Inc.	MSHA		
Washington, TN	Franklin Woods Community Hospital	MSHA	1	8
	HealthSouth Quillen Rehabilitation Hospital	MSHA		
	Johnson City Medical Center	MSHA	456	6
	Woodridge Psychiatric Hospital	MSHA		
Grand Total			932	25
Lakeway data from 2014				
Hospital Name	Cardiac Surgery		Vascular Surgery	Womens Other
Tennova Healthcare-Lakeway Regional Hospital			6	1
Grand Total			6	1
Virginia Hospital County	Hospital Name	System	Vascular Surgery	Womens Other
Buchanan, VA	Buchanan General Hospital	All Other		
Dickenson, VA	Dickenson Community Hospital	MSHA		
Russell, VA	Russell County Medical Center	MSHA		1
Smyth, VA	Smyth County Community Hospital	MSHA		
Tazewell, VA	Carilion Tazewell Community Hospital	All Other		
	Clinch Valley Medical Center	All Other	18	
Washington, VA	Johnston Memorial Hospital	MSHA	60	3
	Wellmont BRMC Ridgeview Pavilion	Wellmont		
Wise, VA	Norton Community Hospital	MSHA	2	1
	Wellmont LPH/MVRMC	Wellmont	3	1
Wythe, VA	Wythe County Community Hospital	All Other	1	
Grand Total			84	6

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients residing within the 21 county service area only.

Exhibit 14

Documents Related to Wellmont's Physician Recruitment Efforts

To be submitted pursuant to CID.

Exhibit 15

Current Duplication of Services

See attached.

Exhibit 15

NOTE: Volume equals 25 or more discharges										
System	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA
Hospital	Dickenson Community Hospital	Franklin Woods Community Hospital	HealthSouth Quillen Rehabilitation Hospital	Indian Path Medical Center	Johnson City Medical Center	Johnson County Community Hospital	Johnston Memorial Hospital	Norton Community Hospital	Russell County Medical Center	Smyth County Community Hospital
County	Dickenson, VA	Washington, TN	Washington, TN	Sullivan, TN	Washington, TN	Johnson, TN	Washington, VA	Wise, VA	Russell, VA	Smyth, VA
Diagnostic Imaging	X	X		X	X	X	X	X	X	X
Emergency	X	X		X	X	X	X	X	X	X
Inpatient Services	X	X	X	X	X	X	X	X	X	X
Cardiac Surgery					273					
Cardiology		240		464	2,050		627	242	119	167
Cardiology Intervention				217	1,203		150			
Endocrinology		137		270	479		223	65	67	68
ENT Surgery										
Gastroenterology		479		974	1,489		817	138	102	104
General Medicine		457		733	1,965		1,237	280	156	230
General Surgery		356		677	1,173		379	90		37
Gynecology		30		56	123		52			
Hematology		34		112	242		88			
Neonatology		338		194	755		165	47		
Nephrology		260		234	842		485	144	94	99
Neurology		82		174	1,138		300	126	29	43
Neurosurgery				81	529					
OB Deliveries Sections		326		216	330		162	54		
OB Deliveries Vaginal		562		358	740		378	83		
OB Other					179		33	26		
Oncology Medicine		39		27	331		58			
Oncology Surgery		46			59					
Ophthalmic Medicine										
Ophthalmic Surgery										
Oral Surgery					30					
Orthopedic Medicine		35		25	403		87			
Orthopedic Surgery				337	1,364		323	32		77
Otolaryngology		46			94		29			
Plastic Surgery										
Psychiatry					92				478	
Pulmonary		572		549	2,086		939	425	312	275
Rehabilitation			420					47		164
Rheumatology					118					
Substance Abuse		26			139		34			
Thoracic Surgery				28	156					
Trauma Medical					122					
Urology Medicine		104			X		31	25		
Urology Surgery		170		34	50		30			
Vascular Surgery					456		60			

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients

Exhibit 15

NOTE: Volume equals 25 or more discharges									
System	MSHA	MSHA	MSHA	Wellmont	Wellmont	Wellmont	Wellmont	Wellmont	Wellmont
Hospital	Sycamore Shoals Hospital	Unicoi County Memorial Hospital, Inc.	Woodridge Psychiatric Hospital	Bristol Regional Medical Center	BRMC Ridgeview Pavilion	LPH/MVRMC	Hancock County Hospital	Hawkins County Memorial Hospital	Holston Valley Medical Center
County	Carter, TN	Unicoi, TN	Washington, TN	Sullivan, TN	Washington, VA	Wise, VA	Hancock, TN	Hawkins, TN	Sullivan, TN
Diagnostic Imaging	X	X		X		X	X	X	X
Emergency	X	X		X		X	X	X	X
Inpatient Services	X	X	X	X	X	X	X	X	X
Cardiac Surgery				231					263
Cardiology	281	51		844		219		114	1,196
Cardiology Intervention				257					683
Endocrinology	153			270		65			328
ENT Surgery									
Gastroenterology	341	79		974		138		56	982
General Medicine	404	82		733		280	28	146	1,048
General Surgery	151			677		90			851
Gynecology				56					141
Hematology	46			112					165
Neonatology				214		48			207
Nephrology	272	49		504		109		59	544
Neurology	112		28	622		36		28	610
Neurosurgery				339					284
OB Deliveries Sections				222		105			268
OB Deliveries Vaginal				427		128			462
OB Other				45		28			45
Oncology Medicine	30			114					130
Oncology Surgery				49					73
Ophthalmic Medicine									
Ophthalmic Surgery						25			
Oral Surgery									
Orthopedic Medicine	28			152					161
Orthopedic Surgery	97			740					1,145
Otolaryngology				26					31
Plastic Surgery				25					26
Psychiatry	154		3,385	820	599				
Pulmonary	663	114		1,291		348	57	185	1,534
Rehabilitation						89		26	
Rheumatology				25					45
Substance Abuse			106	43					26
Thoracic Surgery				57					106
Trauma Medical				42					48
Urology Medicine				45					29
Urology Surgery				84					70
Vascular Surgery				131					257

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients

RESPONSES TO QUESTIONS
SUBMITTED APRIL 22, 2016
BY
TENNESSEE DEPARTMENT OF HEALTH
IN CONNECTION WITH
APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE

Submitted by: Mountain States Health Alliance
Wellmont Health System
Date: July 13, 2016

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RESPONSES TO QUESTIONS

SUBMITTED APRIL 22, 2016

BY

TENNESSEE DEPARTMENT OF HEALTH

IN CONNECTION WITH

APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: July 13, 2016

Additional Request from the Department of Health
Submitted April 22, 2016

Mountain States Health Alliance and Wellmont Health System Response

I. INCOMPLETE (1)

a. Services Offered by Other Providers

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

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

i. **Limit services and products provided to those within the geographic service area;**[1]

RESPONSE: The Parties have attached the information requested above as Exhibit 1, which shows the hospitals providing inpatient services to residents of the Geographic Service Area, and limits the hospitals to only those physically located within the Geographic Service Area. The Parties have several concerns about excluding competitors not physically located in the proposed 21-county Geographic Service Area from the assessment of alternatives and competitive constraints on the Parties. These alternatives are relatively large in number and include major academic medical centers (AMCs) offering an array of services, including more advanced tertiary and quaternary services, specialty hospitals (such as psychiatric facilities), and community hospitals located in adjacent areas. These provide alternatives for commercially insured and other patients. There is clear evidence of market share overlap in these areas despite the existence of state or other political borders. Wellmont and Mountain States believe that the relevant competitive impact coming from organizations physically located outside the proposed 21-county Geographic Service Area is small. However, to the extent it is measurable, the Parties believe it is more accurate to include all competitive impact when analyzing competition within and the effect of the proposed transaction in the proposed 21-county Geographic Service Area. We respectfully suggest that, while exclusion of out-of-area competitors may be one interpretation of the rule, evaluation of post-merger effects should take into consideration responses to any alleged anticompetitive pricing and any repositioning that hospitals and payers may undertake, which would tend to start with identification of those additional competitors. As a result, the Parties respectfully request that the services and product information contained in their original Application dated February 16, 2016 be included in the record so that it is available for analysis.

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

INDEX OF DOCUMENTS:

- Exhibit 1 - Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area

ii. **Revise classification of facilities to reflect substitutable services or products;**[2]

RESPONSE: Outpatient facility listings have been revised to exclude five facilities. We have attempted to identify any center that expressly limits services and have considered the examples provided. We note that many ASCs have the ability to expand operations beyond current services by bringing on additional physicians/surgeons, and that overly narrow service lines may overstate competitive issues. A revised list of facilities to reflect substitutable services or products is attached as Exhibit 2.

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- Exhibit 2 - Revised Classification of Facilities to Reflect Substitutable Services or Products

iii. **Provide information on the structure of physician practices to calculate the appropriate market share.**[3]

RESPONSE: The Parties are calculating the appropriate market share for physician practices as requested and will provide this information to the Department as soon as possible.

INDEX OF DOCUMENTS:

- Exhibit 3 - Information on the Structure of Physician Practices (to be provided in a subsequent response)

iv. **Identify physicians under an exclusive contract or arrangement with either applicant or a subsidiary of either applicant.**

RESPONSE: The list of physicians under an exclusive contract or arrangement with either applicant or a subsidiary of either applicant will be provided under CID to the Attorney General's Office.

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

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

INDEX OF DOCUMENTS:

- Exhibit 4 - Physicians Under an Exclusive Contract (considered confidential information and will be subsequently filed)

b. Description of the Competitive Environment
Tenn. Comp. R. & Regs. 1200-38-01-.02(2) (a) 13 (v)

Recalculate market shares using appropriate geographic market and output measures.[4]

RESPONSE: The Parties have attached the information requested above as Exhibit 5, which presents shares based on discharges in the Geographic Service Area. As noted above in Section I(a)(i), the Parties have concerns about excluding competitors not physically located in the proposed 21-county Geographic Service Area from the evaluation of competition and from share measures. These competitors represent alternatives for payers, patients, and their physicians; the data and information show that physicians are referring patients for a large array of services out of the Geographic Service Area to several hospitals, including the leading AMCs and hospitals in Tennessee and Virginia for commercially insured and other payers. These alternatives are very relevant to evaluation of the transaction; retaining and regaining volumes locally with an enhanced integrated delivery network and improved care models are important goals of .the proposed transaction. To accomplish this, the Parties will have every incentive to improve quality and deliver care in cost-effective and high value fashion. As a result, the Parties respectfully request that the market share information contained in the original Application dated February 16, 2016 be included in the record so that it is available for analysis.

INDEX OF DOCUMENTS:

- Exhibit 5 - Recalculation of Market Shares

c. Cooperative Agreement - EXHIBIT 11.1
Tenn. Comp. R. & Regs. 1200-38-01-. 02(2) (a) J 3

i. **Provide a copy of the nonbinding April 2, 2015 Term Sheet referenced in the Master Affiliation Agreement and Plan of Integration, page 1 paragraph 6.**

RESPONSE: A copy of the nonbinding April 2, 2015 Term Sheet is attached as Exhibit 6.

INDEX OF DOCUMENTS:

[4] See Incomplete Item I.a.

- Exhibit 6 - Copy of the Nonbinding April 2, 2015 Term Sheet

ii. **Provide the following exhibits referenced in the Master Affiliation Agreement, page 56:**

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

RESPONSE: The Interim Parent Company Articles are attached as Exhibit 7. The Interim Parent Company Bylaws are attached as Exhibit 8.

INDEX OF DOCUMENTS:

- Exhibit 7 - Interim Parent Company Articles
- Exhibit 8 - Interim Parent Company Bylaws

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

RESPONSE: The Amended Parent Company Articles will not be adopted until at or shortly before the closing. The only two changes that will be made to the current Interim Parent Company Articles are (1) to change the principal place of business to the office location selected by the Parties and (2) to change the name from "Newco" to the permanent name selected by the Parties.

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

RESPONSE: The Amended Parent Company Bylaws will not be adopted until at or shortly before the closing. A draft of the Amended Parent Company Bylaws is attached as Exhibit 9.

INDEX OF DOCUMENTS:

- Exhibit 9 - Amended Parent Company Bylaws

II. **INCOMPLETE (2)**

a. Potential Disadvantages

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

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

RESPONSE: A detailed explanation of any potential disadvantages that may result from the Cooperative Agreement and how the Parties have proposed to address these potential disadvantages is attached as Exhibit 10. The Parties have also included an explanation of each of the likely benefits resulting from the agreement to be weighed against the potential disadvantages. By way of overview, we note that the agreement

provides a unique opportunity to create a fully integrated patient-centric healthcare delivery network with common infrastructure supporting technologies and care models, coordinated care, and needed investments in population health in the largely rural communities characteristic of the Geographic Service Area. These represent advantages and consumer and community benefits that are unlikely to occur absent this transaction.

INDEX OF DOCUMENTS:

- Exhibit 10 - Benefits and Potential Disadvantages that may Result from the Cooperative Agreement

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

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

RESPONSE: The New Health System does not intend to increase its market share in Harlan and Letcher in Kentucky; or Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina.

c. Insurance Contracts / Proposed use of any Cost Savings to Reduce Prices Borne by Insurers and Consumers [5]
Tenn. Comp. R. & Regs. 1200-38-01-.02(2) (a) 13 (vii) (111)1 II
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13(ix)(I)

i. **Provide the number of current insurance contracts that represent less than 2% of patient services revenue.**

RESPONSE: Wellmont has sixty-eight current insurance contracts that each represent less than 2% of patient services revenue. A list of these sixty-eight insurance contracts (in alphabetical order) is provided as Exhibit 11.

Mountain States has one hundred sixty-one current insurance contracts that each represent less than 2% of patient services revenue. A list of these one hundred sixty-one insurance contracts (in alphabetical order) is provided as Exhibit 12.

INDEX OF DOCUMENTS:

- Exhibit 11 - List of Wellmont's Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue
- Exhibit 12 - List of Mountain States' Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue

[5] See Application pp. 46 and 47.

ii. **Identify any potential insurers that would represent less than 2% of patient services revenue that do not currently contract with either system.**

RESPONSE: The Parties are not aware of any insurer that is active in the area that would represent less than 2% of patient services revenue and does not currently contract with either system.

iii. **Detail the percent of current insurance contracts that have fixed rate increases as written. Provide the amount and timing of these currently planned fixed rate increases. You may aggregate these rates separately for MSHA and Wellmont if you include the mean and standard deviation of the planned fixed rates.**

RESPONSE: Less than six percent of Mountain States' current insurance contracts have fixed rate increases as written. Sixteen percent of Wellmont's current insurance contracts have fixed rate increases as written.

The amounts and timing of Wellmont's and Mountain States' respective currently planned fixed rate increases will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 13 - Mountain States' Currently Planned Fixed Rate Increases (considered confidential information and will be subsequently filed)
- Exhibit 14 - Wellmont's Currently Planned Fixed Rate Increases (considered confidential information and will be subsequently filed)

iv. **Provide the negotiated rate increases for the past five years. These increases should be calculated using the same methodology proposed in the commitment to not increase negotiated rates for hospital, physician or non-hospital outpatient services by more than the hospital or medical care Consumer Price Index minus 0.25%.**

RESPONSE:

The negotiated rate increases for the past five years calculated using the same methodology proposed in the commitment to not increase negotiated rates for hospital, physician, or non-hospital outpatient services will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 15 - Mountain States' Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services (considered confidential

information and will be subsequently filed)

- Exhibit 16 - Wellmont's Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services (considered confidential information and will be subsequently filed)

v. **Detail the proposed methodology to cap negotiated rates, including whether contractual out-of-pocket payments will be included.**

RESPONSE: For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%.

For example, if the current multi-year managed care contract between Wellmont or Mountain States and the payer included an automatic annual Inflator of 4% and Medical CPI was 3%, the New Health System's rate cap would then reduce that inflator to 2.75% (25 basis points less than Medical CPI). This provision will automatically apply to all current contracts that remain in force as well.

The Parties have proposed that this provision only apply to contracts with negotiated rates and should not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, the Parties have proposed that baseline rates or estimated reimbursement for inpatient and outpatient services for an expiring contract at the point of its expiration be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes for subsequent years.

Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of a natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index.

Following approval of the COPA, if the New Health System and a Principal Payer[6] are unable to reach agreement on a negotiated rate, the New Health System agrees to mediation as a process to resolve any disputes.

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

The Parties anticipate that the cap on negotiated rates will be of substantial benefit to payers, employers, and consumers. With high-deductible health plans growing in popularity, and with the consumer bearing more of the financial responsibility for the cost of their care, the consumer's out-of-pocket payments will benefit from the use of these rate caps.

It should be noted that payers and employers determine all of the health plan designs, which result in how much out-of-pocket costs the consumers ultimately bear. The New Health System has no role or control over the establishment of how much the out-of-pocket costs are and will not even know what an individual patient's financial responsibility is until the service has been delivered and the claim has been adjudicated by the payer. With a high-deductible plan, the patient may owe essentially all of the contracted rate for services early in their plan year, but may owe nothing for the same services later in their plan year once the patient has already met their annual high deductible.

As high-deductible plans have become increasingly common, both Parties have seen an increase in the percentage of payments paid by individual patients versus payers. This trend has negatively impacted collection rates for both Parties which in turn has led to increases in charity care and bad debt. The New Health System has no control over the amount owed by individual patients under each individual health plan and, by law, is prohibited from waiving the co-pays and deductible amounts an individual may owe based on their plan design.

vi. **Detail how the New Health System will handle price setting for uninsured or private pay patients.**

RESPONSE: The New Health System will continue to treat all patients with dignity, compassion, and high-quality care standards regardless of their social status or ability to pay. The New Health System's charity care policy will comply with all state and federal regulations in regard to charity care and essential hospital access and will be consistent with the New Health System's role as a public benefit, not-for-profit, tax-exempt corporation. The policy will be published, and all patients will be advised of their ability to access services under the policy. The policy will apply at the time of service delivery rather than after collection attempts have been made. Patients will have no barriers to receiving needed care. The New Health System will place no dollar limits on the amount of charity care it will provide and commits to providing a charity care policy that incorporates the best elements of the current policies of each Applicant. In fact, the New Health System's charity care policy will increase the benefit for charity care above and beyond what either of the Applicants currently provide. The new policy will provide a 100% discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the

Federal Poverty Level, with a sliding scale applying to certain patients.

Uninsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that Section, governing not-for-profit organizations, and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible. It is the goal of the New Health System to provide services to members of the community in a manner that is compassionate, fair, and reasonable and that does not result in an undue financial burden.

The New Health System will take other steps to benefit needy patients. One of the New Health System's stated goals is to reduce unnecessary utilization of high cost emergency department and inpatient services by uninsured individuals. So-called "super-utilizers" of health care consume a disproportionate level of health care resources and often have co-existing medical conditions coupled with addiction and mental health issues and social resource needs.

The New Health System will design an effective case management model for this "super-utilizer" population, once identified, that is proactive. Elements of the program will include social needs screening and assessment (transportation, food and housing insecurity, high risk behaviors or environments, etc.), connection to primary care preferably in a patient-centered medical home model for disease management, connection to health care and social resource navigators and community health workers, and connection to medication assistance. The New Health System will also provide resources for individuals who are ready to receive intervention for unhealthy behaviors that contribute to poor health. Findings from previously conducted model programs will be used to inform and create the overall plan. Partnerships with regional Federally Qualified Health Centers, Rural Health Centers, Health Departments, and charity clinics will be essential.

For individuals who agree to comply with certain requirements such as following physician prescriptions and orders, keeping scheduled appointments, participating in appropriate screenings, and participating in education related to chronic conditions or healthy lifestyles, the New Health System will provide guaranteed access to program services and medical care and the discount for services will be increased substantially.

This model can be a precursor to other population health models which can apply to other high-utilizer populations and may even be a source for translational research studies to result in best practice program development—especially in rural environments.

d. Common Clinical IT and Health Information Exchange

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

i. **Provide your anticipated 10-year timeline with milestones for development and implementation for both the Common Clinical IT platform, connectivity for information exchange and quality measurement reporting. At a minimum, the timeline should include targeted objectives for each year following the formation of the New Health System, including target dates for the following activities:**

1. **Behavioral health capability. If your chosen Clinical IT system does not currently include a behavioral health module, detail your plans here, including integration or interoperability of electronic behavioral health record systems from third-party vendors.**

2. **Integration of systems and / or linkage of records (medical, lab, pharmacy, diagnostic, and referral / scheduling).**

3. **Migration and / or archiving of pre-existing records.**

4. **Training for new users (System and non-System providers).**

5. **Patient access to information.**

6. **Capabilities for collecting, analyzing and reporting quality outcomes (clinical, cost, patient satisfaction, etc.) for providers (System and non-System).**

RESPONSE: If the COPA is approved, the Parties expect the New Health System to assess each party's existing electronic health records computer platform(s), including third party systems, hardware, software, computer infrastructure, etc., to determine the roadmap to bring the New Health System onto a Common Clinical IT Platform, as described in the Application. This assessment is expected to take at least six months after the New Health System is formed. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, a high-level timeline for implementation of the Common Clinical IT Platform is included as Exhibit 17 for reference.

INDEX OF DOCUMENTS:

Exhibit 17 - Anticipated 10-Year Timeline

ii. **Provide estimates for how and when the $150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated, including but not limited to the amount designated for the Common Clinical IT Platform, the amount designated for connectivity with non-System providers, population health management and quality reporting capabilities. If relevant, provide estimated costs to offer EHR solutions for non-System providers, and estimated expenses to support connectivity for**

non-System providers, along with estimates for any revenue projected to be realized from any services offerings related to these capabilities.

RESPONSE: The estimates for how and when the $150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated, including but not limited to the amount designated for the Common Clinical IT Platform, the amount designated for connectivity with non-System providers, population health management and quality reporting capabilities is attached as Exhibit 18.

INDEX OF DOCUMENTS:

- Exhibit 18 - Estimates for How and When the $150 Million Investment in a Common Clinical IT Platform and Health Information Exchange will be Allocated

iii. **Describe the current commitment and timeframe for participation of both MSHA and Wellmont in OnePartner, the operational regional health information exchange. Also describe the options and plans for future participation (e.g., continued participation or acquisition of OnePartner, participation with a competing HIE provider, or development of a competing service offering).**

RESPONSE: A description of both Parties' use of health information exchanges ("HIEs") with information showing the current system used by each party, including current usage, how information is shared, fees or costs paid to use the system and the number of other providers currently using the system, how the records are shared, and the extent of patient records included in the exchange is attached as Exhibit 19.

Both Wellmont and Mountain States are currently participating in OnePartner. It is expected that the New Health System will meaningfully participate in a health information exchange, however, specific details about which health information exchange the New Health System will participate in have not been decided at this time.

INDEX OF DOCUMENTS:

- Exhibit 19 - Current Commitment and Timeframe for Participation of both MSHA and Wellmont in OnePartner

e. **Total Cost Resulting from Cooperative Agreement**
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a) 15

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

Provide documentation of the availability of the necessary funds.

RESPONSE: The Parties' combined expenses associated with the Cooperative Agreement are set forth below. The Parties have not incurred any capital costs related to the merger. The management, staff and board members of both Parties have spent thousands of hours working on the potential merger, but this time is not accounted for separately. All expenses related to the merger are paid on a monthly basis.

Expense Category	Expense Incurred as of June 15, 2016
Communication Services	$1,129,408
Consulting Services	$2,260,548
COPA Fees*	$104,958
Due Diligence Services	$2,497,435
Legal Services	$10,496,155

* COPA Services include the filing fees and expenses that have been paid to the Southwest Virginia Health Authority and the Tennessee Department of Health.

f. **Description of Financial Performance**
Tenn. Comp. R. & Regs. 1200-30-01-02(2)(a) 13(vii)

i. **The description and summary of financial performance of Wellmont and MSHA does not adequately detail all components noted by department rule.**

RESPONSE: Application Exhibits 11.4 Attachments D and E were submitted in Addendum #1 to the COPA Application on March 17, 2016. Exhibit 11.5 Attachment D was submitted by Wellmont to the Attorney General's Office under CID on May 12, 2016.

ii. **Provide additional detail on the activities to be funded by the following proposed community reinvestment: 1) the $75 million investment in population health improvements; 2) the $140 million to expand mental health, addiction recovery, substance abuse prevention programs; and 3) the $85 million to develop and grow academic and research opportunities.[7]**

RESPONSE: As explained in the Application, the Parties have committed to reinvesting savings over the next ten years in the following categories:

- $75 million towards population health improvements
- $140 million towards the expansion of needed services which includes:
  - $85 million for mental health and addiction recovery
  - $27 million for pediatric sub-specialty access
  - $28 million for rural health access; and
- $85 million to develop and grow academic and research

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

opportunities.

Additional detail on the activities to be funded by the proposed community reinvestment is attached as Exhibit 20.

INDEX OF DOCUMENTS:

- Exhibit 20 - Additional Detail on the Proposed Community Reinvestment

iii. **Complete the "Year-by-Year Summary" that requests an estimate of the year-by-year timing of reinvestments and cost savings. (See Attachment 1)**

RESPONSE: The New Health System commits to using reinvestments and cost savings to implement programs and strategies to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and neonatal abstinence syndrome in the Geographic Service Area, as outlined in the template Community Health Improvement Plan, attached as Exhibit 21. The "Year-by-Year Summary" that provides an estimate of the year-by-year timing of these reinvestments and cost savings is attached as Exhibit 22.

INDEX OF DOCUMENTS:

- Exhibit 21 - Template Community Health Improvement Plan
- Exhibit 22 - Year-by-Year Summary

iv. **Provide an updated amount of net expenditures on community health improvement, health professions education, and research as detailed on your most recent IRS Form 990 Schedule H.[8]**

RESPONSE: Below are the net expenditures on community health improvement, health professions education, and research for Mountain States and Wellmont based on each organization's 2015 IRS Form 990 Schedule H.

	Mountain States	Wellmont
Community Health Education and Outreach	$4,113,567	$5,761,249
Health Professions Education	$9,276,052	$5,748,416
Research	$237,449	$140,715

v. **Detail whether a $75 million investment in population health over ten years represents an increase in spending over that of past community health**

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

investment, and if so, provide an estimate of the aggregate planned population health investment.

RESPONSE: Should the COPA be granted, the investment in population health set forth in the Application represents a net increase of $75 million in aggregate over that of past community health investment for the ten year period following the creation of the New Health System.

vi. **Detail whether an $85 million investment in research and training over ten years represents an increase in spending over that of past research and training investment, and if so, provide an estimate of the aggregate planned research and teaching investment.**

RESPONSE: Should the COPA be granted, the investment in research and training set forth in the application represents a net increase of $85 million in aggregate over the past research and training investment for the ten year period following the creation of the New Health System.

vii. **Compare and contrast the type of programs currently funded by Community Benefit spending, particularly in the categories above, with the planned investment over the next ten years.**

RESPONSE: The Community Benefit spending reported in the Parties' IRS Form 990s and annual reports represent investments in social responsibility efforts which are outside of their clinical core functions. The financial value of the Parties' current Community Benefit spending will serve as a baseline for the new incremental investments the Parties have proposed under the COPA, subject to adjustment for the most current financial performance of the combined systems to ensure the community benefit spending reflects current market conditions.

The Parties' current Community Benefit spending also represents the substantial investments made by our health systems to provide charity care to those in need or to fund uncollectable payments for medical services. It includes investments made by each health system and their respective foundations to improve the delivery of health care and quality of life in the region. This includes providing financial support to outside organizations whose work aligns with the Parties' efforts to improve the overall health status and economic vitality of the region. As explained in the Application, the Parties' plans for incremental investments under the COPA may increase support for certain current efforts as well as fund new efforts.

The Parties' current Community Benefit spending includes investments in graduate medical education, including residency slots and the internal infrastructure required to support them. The current Community Benefit spending also includes investments in direct support for health professions training along with internships and preceptor work associated with allied health professional training. At any given point, the two health systems are serving

one thousand plus students collectively and supporting their ability to learn in the clinical environment. Again, the investments the Parties plan to make as a part of the COPA will be over and above these current levels of Community Benefit.

In addition to workforce education and training, the Parties currently support many regional efforts to improve community health. Examples of this work include programs sponsored by the two health systems, such as the Mountain States' Morning Mile walking program for area children and Wellmont's Project Fit America program to provide outdoor exercise play equipment and curriculum to schools. Both organizations also support third-party efforts such as Healthy Kingsport, regional YMCA/YWCA programs, Girls and Boys Clubs, and many more organizations and programs which are designed to be catalysts for health improvement. Once the community health improvement goals are agreed upon with the state, the Parties will work collaboratively with local stakeholders to leverage existing programs that are operating successfully and support the establishment of new programs where gaps exist.

By the third year, the reinvestments in community benefit funded through the efficiencies gained by the proposed merger will double the current level of community benefit spending of the Parties as outlined in their most recent 990s and will approach a consistent rate of at least 2.5 times the current level by year five. This increase in community benefit spending will be in addition to the substantial financial support the New Health System will offer patients through the provision of charity care and self-pay discounts.

viii. **Provide the audited financial statement on MSHA as of June 30, 2015. (See Exhibits 11.4-F)**

RESPONSE: The audited financial statement on MSHA as of June 30, 2015 is attached as Exhibit 23.

INDEX OF DOCUMENTS:

- Exhibit 23 - Audited Financial Statement on MSHA as of June 30, 2015

ix. **On April 06, 2015, Fitch Ratings placed on Rating Watch Evolving the 'BBB+' rating for Health and Educational Facilities Board of Johnson City, TN, revenue bonds issued on behalf of MSHA and parity debt issued on behalf of MSHA listed in April 06, 2015 press release. Provide the current status regarding Fitch's Rating Watch. (See Exhibits 11.4-H)**

RESPONSE: Mountain State's current Fitch Ratings Watch is attached as Exhibit 24.

INDEX OF DOCUMENTS:

- Exhibit 24 - Mountain State's current Fitch Ratings Watch

g. Efficiencies in Operating Costs and Shared Savings

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

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

RESPONSE: The report prepared by FTI Consulting, Inc. that details the assumptions used in calculating the proposed economies and efficiencies of the proposed merger will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 25 - FTI Consulting Report (considered confidential information and will be subsequently filed)

III. GENERAL COMMENTS

a. **Detail how an additional layer of governance (i.e., the parent company) benefits the organization.**

RESPONSE: The creation of the New Health System as the sole member, and essentially the "holding company", of the currently existing corporations of Wellmont and Mountain States is critical to preserving the cash flow of the combined entity. If the Parties were to merge one of the existing corporations (Wellmont Health System/Mountain States Health Alliance) into the other, that would be considered a change of ownership by the Centers for Medicare and Medicaid Services ("CMS").

A change of ownership requires that CMS issue new provider numbers. The process of applying for and receiving new provider numbers takes between three and six months, during which time CMS will not pay for services rendered at the hospitals undergoing a change in ownership. Approximately one-half (1/2) to two-thirds (2/3) of the cash flow from the involved hospitals would be withheld during this three to six month period of time due to the level of government-paid patient volumes seen at those hospitals. While CMS will ultimately pay for such services after new provider numbers are issued, the interruption of such a significant amount of the cash flow for the New Health System would be crippling. By putting the New Health System in place, the merger is not considered a change of ownership by CMS, thereby avoiding a debilitating cash-flow interruption. Primary governance functions of the New Health System will account for the majority of all governance activities since the New Health System will become the sole member of the existing Wellmont and Mountain States entities. The current organizations will limit governance to those essential functions that need to be retained for basic corporate oversight. Thus, the new structure will not create any significant redundancy of governance functions.

b. **Provide an organizational chart that shows the resulting institution.**

RESPONSE: Exhibit 26 includes an organizational chart that shows the resulting New Health System.

INDEX OF DOCUMENTS:

- Exhibit 26 - Organizational Chart

c. **Clarify the amount of current debt and what is proposed in debt repayment and/or incurring additional debt as a result of this proposal.**

RESPONSE: Exhibit 27 shows the current debt for Mountain States as of third quarter FY2016. Exhibit 28 shows the current debt for Wellmont as of third quarter of FY2016. The assumption on debt repayment in the FTI model is: the repayment schedules for both organizations will remain the same. However, the Parties currently project, based on current market conditions, that significant savings opportunities exist for restructuring debt. The savings have not been incorporated into the model because the Parties cannot accurately predict the amount of savings that could be achieved at the time the transaction closes.

The FTI model assumes that NewCo will not incur any additional debt as a result of the transaction.

INDEX OF DOCUMENTS:

- Exhibit 27 - Mountain States' Q3 FY2016 Financials and Maximum Annual Debt Service Coverage Ratio
- Exhibit 28 - Wellmont's Third Quarter FY2016 Financial Statements

d. **Provide details regarding severance packages, including but not limited to, timing of implementation and dollar amount. Include details of severance packages currently being paid. (See Application p. 61)**

RESPONSE: Details regarding each Party's severance packages will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 29 - Details Regarding Mountain States' Severance Packages (considered confidential information and will be subsequently filed)

- Exhibit 30 - Details Regarding Wellmont's Severance Packages (considered confidential information and will be subsequently filed)

e. **Provide proposed employment agreements mentioned in the application.**

RESPONSE: The proposed employment agreements mentioned in the Application will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 31 - Proposed Employment Agreements with New Health System

(considered confidential information and will be subsequently filed)

f. **Describe the proposed performance parameters that will be used to measure employee performance.**

RESPONSE: The New Health System will implement a set of performance standards that incentivize all team members to pursue objectives to increase clinical quality, improve the patient experience, and achieve the financial goals of the New Health System. These parameters will be established based on annual goals which will be approved by the governing board once the New Health System is established. These parameters will be communicated clearly and proactively to team members. Overall performance will also be evaluated against the efforts of individual employees to contribute to the achievement of the New Health System's mission, vision, and values.

g. **The resulting board appears to be comprised of nine (9) members, of which only eight (8) will be voting members. Identify and/or detail how the board would deal with a 4/4 vote.**

RESPONSE: As noted in the Application,[9] the New Health System will be governed exclusively by its board of directors, which is the fiduciary board responsible for the delivery of quality care in consideration of the needs of the communities served by the system. The board of directors of the New Health System will be composed of fourteen (14) voting members, as well as two (2) ex-officio voting members and one ex-officio non-voting member.

Wellmont and Mountain States will each designate six (6) members to serve on the initial board of directors of the New Health System. In addition, Wellmont and Mountain States will jointly select two (2) members of the initial New Health System board, who will not be incumbent members of either Party's board of directors. The two (2) ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The sole ex-officio non-voting member will be the then-current President of ETSU.

Pursuant to the Bylaws of the New Health System, to be approved, actions of the Board of Directors require the affirmative vote of at least a majority of the voting directors at a meeting at which a quorum is present. Therefore, tie votes would result in disapproval of the motion under consideration by the board.

h. **Provide the Physician Needs Assessment from Niswonger Children's Hospital and detail how recruitment strategy will differ post-merger.**

RESPONSE: The Physician Needs Assessment for Niswonger Children's Hospital will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

[9] *See* Application Section 11(b).

- Exhibit 32 - Physician needs Assessment from Niswonger Children's Hospital (considered confidential information and will be subsequently filed)

IV. INCONSISTENCIES

The applicants should address the inconsistencies noted below.

Exhibit 11.4, pages 3 and 5 (Adobe pgs. 709 and 711/2578)	**The Statement of Operations summary for the fiscal year ended June 30, 2014 did not always appear to agree with amounts presented on the financial statement included in the application (Exhibit 11.4, Attachment F). For example, the summary reported net patient revenue decreased by $3.8 million; however, the audited financial statement (Adobe pg. 1538/2578) reflected a decrease of $4.96 million. Additionally, the Balance Sheet summary for the fiscal year ended June 30, 2014 stated that part of the reason for the increase in assets was due to an increase in patient receivables; however, the Consolidated Balance Sheet (page 1536/2578) reflected a decrease in patient accounts receivable of approximately $3 million from the prior year.**

RESPONSE: Internal financial packages were used to provide the calculations in the summary provided in the Application. Mountain States has attached calculations to demonstrate the variances in the REVISED summary (attached). All changes have been bolded. The variance between the internal financials and audited financials and explanations for the changes in the summary are:

A. The internal financials do not have eliminations for Mountain States' employee health plan. These eliminations (1) reduce net revenue and (2) reduce benefit expense. The benefit eliminations are included in the audited financials. The summary has been revised to include the benefit eliminations amounts.

B. The internal financial package includes incentive pay as a non-operating expense. The audited financials classify incentive pay in salaries and wages. The summary reflects incentive pay in non-operating expenses.

C. The FY2012 internal financial package includes the loss on early extinguishment of debt as a non-operating expense. The audited financials classify the loss as an expense in the prior year in the new audited format for FY2013. The summary reflects the loss on extinguishment as non-operating and the loss on extinguishment is therefore excluded from the income from operations calculation.

D. The FY2015 audited financials include an elimination for Mountain State's owned Medicare Advantage insurance plan. These eliminations (1) reduce net revenue and (2) reduce medical cost. This elimination was not done in FY2014. The FY2014 audited financials have been revised to be comparable. The summary has been revised to reflect these benefit eliminations.

The summary was written before Mountain State's final FY2015 audited financials were

issued. Therefore, the summary was based on preliminary unaudited results. The summary has been updated to reflect the final audited results for FY2015.

From time to time, items may be reclassified in Mountain States' audited financial statements. When comparing prior years, the numbers may not match exactly due to the reclassifications. These reclassifications are completed in order to make the financial statements comparable.

For example, in FY2012, per new accounting guidance, bad debt expense was included as a deduction from net revenue. Also, revenue associated with Mediserve Durable Medical Equipment was classified as Other Revenue instead of Patient Revenue. The FY2011 audited financials were revised to be consistent with the new FY2012 classification. The summary has been revised to reflect these changes. The FY2012 comparison is based on the FY2012 audited financial as compared to the FY2011 audited financial adjusted for the bad debt expense and durable medical equipment revenue reclassifications.

In FY2013, the format of Mountain States' audited financial was changed. There is no differentiation between operating and non-operating revenue and expenses. The audited results for FY2013 to FY2015 are attached as Exhibit 33 in a comparable format that was used for FY2011 and FY2012.

INDEX OF DOCUMENTS:

- Exhibit 33 - Audited Results for FY2011 to FY2015

Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015 and Material Event Disclosures (as listed on page 126) (Adobe pg. 128/2578)	**The exhibit was not included in the application.** **This exhibit was not included in the list of excluded information on page 119; therefore, it appears to have been omitted from the application in error.**

RESPONSE: Exhibit 11.5 - Attachment C was inadvertently omitted from the Application. It is attached to this response as Exhibit 34.

INDEX OF DOCUMENTS:

- Exhibit 34 - Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015

Exhibit 11.8, page 2 (Adobe pg. 2500/2578)	**The "Timing and Phases of Efficiency Assumptions" section stated that no efficiency savings are projected to be implemented in whole or in part until the FYE 6/17; however, the "Preliminary Efficiencies" Model Income Statement appeared to reflect savings of $41,144 over the "Baseline" model for the FYE 6/16 (i.e., savings of $21,632 in medical supplies and drugs, $5,651 in purchased services, $1,002 in maintenance and utilities, and $12,859 in other).**

RESPONSE: The "Timing and Phases of Efficiency Assumptions" description included savings that could be negotiated on day one. Since these contract changes would occur at the start of the merger FTI assumed the impact would be immediate. In the "Baseline" model, FTI has updated the timing in the second run of the model to start FYE 6/17 which reflects the current anticipated timeline. The updated Financial Model is attached as Exhibit 35.

INDEX OF DOCUMENTS:

- Exhibit 35 - Updated Financial Model

Exhibit 11.8, page 9 (Adobe pg. 2507/2578)	**It appears, for the forecasted columns of the "Baseline" Model Balance Sheet, total net assets should equal the prior year ending net assets balance plus revenues in excess of expenses reported on the operating statement on the previous page. However, the total net assets balances reported on the "Baseline" Model Balance Sheet in the 2016 through 2020 columns did not equal this. The difference appears to be related to the income attributable to non-controlling interests.**

RESPONSE: For the forecasted columns of the "Baseline" Model Balance Sheet, the assumptions in the baseline were that the Company post-merger would have to payout each Joint Venture entity's interest, while currently the separate hospitals do not appear to make those distributions and allow each Joint Venture entity to maintain the cash balance. The total net asset balances reported in the Baseline Model Balance Sheet in the 2016 through 2020 columns have been updated to match the baseline assumption, that the Joint Venture entities do not make distributions and retain the cash. See attached Exhibit 35.

Exhibit 11.8, pages 12 and 13 (Adobe pgs. 2510-11/2578)	**On the "Preliminary Efficiencies" Model Cash Flows, the cash flows from financing activities included amounts for each year for payments made related to income attributable to non-controlling interest. However, it appears the "Preliminary Efficiencies" Model Balance Sheet on the previous page reflected this amount as part of net assets each year (i.e., the non-controlling interest component of net assets increased each year by the amount of income attributable to non- controlling interest).**

RESPONSE: See explanation immediately above. The updated Financial Model is attached as Exhibit 35.

Exhibit 11.8 - pages 10 and 13	**The amounts reflected for Payments on LTD and liabilities (net of interest) on the "Baseline" and "Preliminary Efficiencies" Model Statement of Cash Flows**

(Adobe pgs. 2508 and 2511/2578)	**were not consistent with amounts disclosed in the debt service schedules presented in the most recent financial statements included in the application. The financial model notes referenced a "Debt Schedule" (page 6) which may provide explanation; however, this schedule was not included with the model. It was expected that the LTD and liabilities payments would agree with debt service amounts presented in the notes to the financial statements (Exhibits 11.4, Attachment F and 11.5, Attachment B) (Adobe pgs. 1559 and 2421/2578).**

RESPONSE: The original financial model did not include an assumption that the New Health System would pay down particular tranches of debt. The assumption was that the New Health System would refinance each tranche as it became due. Additionally, one of the goals of this exercise was not to disclose any of the specific detail of information that each individual health system would be able to use to gain a greater insight into the other health system's financial performance. If FTI used specific debt schedules from each health system then the health systems would have been able to extrapolate competitively sensitive information.

INDEX OF DOCUMENTS

Exhibit 16 Wellmont's Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services
To be submitted pursuant to CID.

Exhibit 17 Anticipated 10-Year Timeline

Exhibit 18 Estimates for How and When the $150 Million Investment in a Common Clinical IT Platform and Health Information Exchange will be Allocated

Exhibit 19 Current Commitment and Timeframe for Participation of both MSHA and Wellmont in OnePartner

Exhibit 20 Additional Detail on the Proposed Community Reinvestment

Exhibit 21 Template Community Health Improvement Plan

Exhibit 22 Year-by-Year Summary

Exhibit 23 Audited Financial Statement on MSHA as of June 30, 2015

Exhibit 24 Mountain State's current Fitch Ratings Watch

Exhibit 25 FTI Consulting Report
To be submitted pursuant to CID.

Exhibit 26 Organizational Chart

Exhibit 27 Mountain States' Q3 FY2016 Financials and Maximum Annual Debt Service Coverage Ratio

Exhibit 28 Wellmont's Third Quarter FY2016 Financial Statements

Exhibit 29 Details Regarding Mountain States' Severance Packages
To be submitted pursuant to CID.

Exhibit 30 Details Regarding Wellmont's Severance Packages
To be submitted pursuant to CID.

Exhibit 31 Proposed Employment Agreements with New Health System
To be submitted pursuant to CID.

Exhibit 32 Physician needs Assessment from Niswonger Children's Hospital
To be submitted pursuant to CID.

Exhibit 33 Audited Results for FY2011 to FY2015

Exhibit 34 Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015

Exhibit 35 Updated Financial Model

Exhibit 1

Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area

Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area

Hospital Name	Hospital Affiliation	Total Discharges
Total		119,282
Total 21-County Hospitals		108,392
Total Non 21-County Hospitals		10,890
Share Outside 21 County-Area		9.1%
WELLMONT HANCOCK COUNTY HOSPITAL	WHS	179
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	1,012
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WHS	1,160
WELLMONT LONESOME PINE HOSPITAL	WHS	1,704
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	13,000
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	16,773
DICKENSON COMMUNITY HOSPITAL	MSHA	5
JOHNSON COUNTY COMMUNITY HOSPITAL	MSHA	14
WOODRIDGE PSYCHIATRIC HOSPITAL	MSHA	32
QUILLEN REHABILITATION HOSPITAL	MSHA	491
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	MSHA	757
RUSSELL COUNTY MEDICAL CENTER	MSHA	1,313
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	1,753
NORTON COMMUNITY HOSPITAL	MSHA	3,120
SYCAMORE SHOALS HOSPITAL	MSHA	3,167
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	5,138
INDIAN PATH MEDICAL CENTER	MSHA	5,939
JOHNSTON MEMORIAL HOSPITAL	MSHA	8,123
JOHNSON CITY MEDICAL CENTER	MSHA	22,983
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	543
BUCHANAN GENERAL HOSPITAL	Other	1,041
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,801
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,820
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,011
TAKOMA REGIONAL HOSPITAL	Other	2,270
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,225
CLINCH VALLEY MEDICAL CENTER	Other	4,102
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	Other	4,916

Exhibit 2

Revised Classification of Facilities to Reflect Substitutable Services or Products

Revised Classification of Outpatient Facilities to Reflect Substitutable Services or Products

Service Type	WHS & MSHA Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.7%	5	0	0	0	297	302
Fitness Center	0.0%	0	0	0	0	82	82
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	9.1%	3	0	2	0	50	55
Physical Therapy	7.8%	1	0	3	0	47	51
Home Health	19.6%	8	0	2	0	41	51
Rehabilitation	39.5%	9	0	8	0	26	43
CT	59.5%	12	0	10	0	15	37
MRI	52.9%	11	0	7	0	16	34
Surgery - Endoscopy	58.3%	9	0	5	0	10	24
Urgent Care	57.1%	8	0	8	0	12	28
Surgery - Hospital-based	58.3%	9	0	5	0	10	24
Dialysis Services	0.0%	0	0	0	0	20	20
Wellness Center	18.8%	2	0	1	0	13	16
Surgery - ASC	66.7%	2	0	3	3	4	12
Chemotherapy	62.5%	4	1	5	0	6	16
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	60.0%	3	0	3	0	4	10
Cancer Center	60.0%	3	0	3	0	4	10
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	3	3
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

*Excluded 3 facilities under ASC and 2 under Urgent Care
ASCs excluded - The Regional Eye Surgery Center, Reeves Eye Surgery Center, and Johnson City Eye Surgery Center; Urgent Care Centers excluded - Patmos EmergiClinic and Doctors Care

Exhibit 3

Information on the Structure of Physician Practices

This Exhibit will be provided in a subsequent response.

Exhibit 4

Physicians Under an Exclusive Contract

To be submitted pursuant to CID.

Exhibit 5

Recalculation of Market Shares

Recalculation of Shares in NEWCO Geographic Service Area for Hospitals Located in Area

Hospital Name	Hospital Affiliation	Total	Shares of Total Discharges	Shares of WHS and MSHA Discharges	Shares of Hospitals in 21-County Area
Total		119,282	100.0%		
Total 21-County Hospitals		108,392	90.9%		
Total Non 21-County Hospitals		10,890	9.1%		
Share Outside 21 County-Area		9.1%			
WELLMONT HANCOCK COUNTY HOSPITAL	WHS	179	0.2%	0.2%	0.2%
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	1,012	0.8%	1.2%	0.9%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WHS	1,160	1.0%	1.3%	1.1%
WELLMONT LONESOME PINE HOSPITAL	WHS	1,704	1.4%	2.0%	1.6%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	13,000	10.9%	15.0%	12.0%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	16,773	14.1%	19.4%	15.5%
DICKENSON COMMUNITY HOSPITAL	MSHA	5	0.0%	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	MSHA	14	0.0%	0.0%	0.0%
WOODRIDGE PSYCHIATRIC HOSPITAL	MSHA	32	0.0%	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	MSHA	491	0.4%	0.6%	0.5%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	MSHA	757	0.6%	0.9%	0.7%
RUSSELL COUNTY MEDICAL CENTER	MSHA	1,313	1.1%	1.5%	1.2%
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	1,753	1.5%	2.0%	1.6%
NORTON COMMUNITY HOSPITAL	MSHA	3,120	2.6%	3.6%	2.9%
SYCAMORE SHOALS HOSPITAL	MSHA	3,167	2.7%	3.7%	2.9%
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	5,138	4.3%	5.9%	4.7%
INDIAN PATH MEDICAL CENTER	MSHA	5,939	5.0%	6.9%	5.5%
JOHNSTON MEMORIAL HOSPITAL	MSHA	8,123	6.8%	9.4%	7.5%
JOHNSON CITY MEDICAL CENTER	MSHA	22,983	19.3%	26.5%	21.2%
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	543	0.5%		0.5%
BUCHANAN GENERAL HOSPITAL	Other	1,041	0.9%		1.0%
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,801	1.5%		1.7%
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,820	1.5%		1.7%
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,011	1.7%		1.9%
TAKOMA REGIONAL HOSPITAL	Other	2,270	1.9%		2.1%
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,225	2.7%		3.0%
CLINCH VALLEY MEDICAL CENTER	Other	4,102	3.4%		3.8%
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	Other	4,916	4.1%		4.5%
UNIVERSITY OF TENNESSEE MEDICAL CENTER	Other	1,764	1.5%		
CARILION MEDICAL CENTER	Other	1,159	1.0%		
TENNOVA HEALTHCARE-PHYSICIANS REGIONAL MEDICAL CEN	Other	1,045	0.9%		
UNIVERSITY OF VIRGINIA MEDICAL CENTER	Other	862	0.7%		
VANDERBILT UNIVERSITY HOSPITALS	Other	856	0.7%		
All Other		5,204	4.4%		

Exhibit 6

Copy of the Nonbinding April 2, 2015 Term Sheet

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

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

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

B. Upon execution of this term sheet or similar legal document, Wellmont and Mountain States will each nominate an equal number of their existing board members to become members of the pre-closing Joint Board Task Force. Further, the CEOs of Wellmont and Mountain States will each serve on the Joint Board Task Force. The total number of members of the Joint Board Task Force will not exceed 14. This Joint Board Task Force will oversee the pre-closing activities of the Integration Council. Given the significance of issues to be managed pre-closing, it is highly desirable the individuals who are selected to serve on the Joint Board Task Force also be those who will ultimately serve on the Newco Board.

C. The initial Newco governing board will be comprised of 14 voting members, as well as two ex-officio voting members and one (1) ex-officio non-voting member. The two ex-officio voting members shall be the Newco Executive Chairman/President and the Newco Chief Executive Officer.

1. The Newco Chief Executive Officer will serve as a voting member of the Newco Board for not longer than two (2) years. At the conclusion of the Chief Executive Officer's two (2) year term, the Chief Executive Officer will rotate off the Newco Board. Upon rotation of the Chief Executive Officer off of the Newco Board, the initial Wellmont designees to the Newco Board (as described in Section D. below) shall appoint a new member to the Newco Board to replace the Chief Executive Officer. The initial term of this new Board member shall be three (3) years, with the opportunity to serve on additional three (3) year term.
2. The one ex-officio non-voting member shall be the then current President of East Tennessee State University.
3. The Board shall include not less than 4 licensed physicians who are members of the medical staff of one or more Newco-affiliated hospitals, with at least two (2) physicians from each legacy system. The total Newco board shall be composed of a maximum of sixteen (16) voting members.
4. Should there be a change in the Executive Chairman/President within the first twenty-four (24) months, for any reason, it is the intent of both Parties to define a process for inclusion in the Definitive Agreement that would maintain the balance of the Newco Board between the legacy systems.

D. Wellmont and Mountain States will each designate 6 members to serve on the initial board of Newco. Wellmont and Mountain States will jointly select 2 members of the initial Newco board, who will not be incumbent members of either Party's board.

E. The initial members of the Newco board will be selected with the goals of

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

F. The initial Newco board appointments will be for staggered terms, with 6 members having a term of two (2) years, four (4) board members with terms of three (3) years, and four (4) board members with terms of four (4) years. The two (2) Board members jointly appointed by the initial Wellmont and Mountain States members shall be in the class with an initial four-year term. The initial board members may serve their initial terms and one additional three-year term. Thereafter, limits on the number of terms of service for board members who succeed the initial board members will be agreed upon and set forth in the Newco bylaws to be adopted at the closing. For the first four years, the staggered terms shall be constructed so that legacy Board members from Wellmont and Mountain States will roll off the Board in equal numbers. If a legacy member resigns or is removed from office during his or her initial term, the person appointed to that position shall come from the same legacy organization and shall serve the unexpired term. Any renewal terms shall be subject to customary board governance policies and procedures.

G. As and after the initial board terms expire, the Newco board will be self-perpetuating. Newco bylaws will provide that Board members will be subject to term limits as discussed above.

H. The Newco board will have the ultimate fiduciary duties and governing role for the key business decisions, activities and management of the new health system. The Newco Board shall adopt governance best practices, including periodic performance evaluation. The governance best practices shall be further enumerated in the Newco bylaws.

I. The Definitive Agreement shall provide for an Executive Chairman (see Section IX *infra*) and a Vice Chairman/Lead Independent Director (to be nominated by Wellmont and affirmed by the non-management members of the Joint Board Task Force and named in the Definitive Agreement) whose responsibilities will be substantially similar to the description attached as Exhibit B to this term sheet. The term of the initial Vice Chairman/Lead Independent Director will be two years after the closing.

J. The Officer and Executive Committee positions of the Newco Board will be defined in the initial Newco Bylaws to be adopted in accordance with the Definitive Agreement. There will be 4 Board Officer positions to be filled as follows: Executive Chair, Vice Chair, Treasurer, and Secretary. Additionally, there will initially be two at-large members of the Executive Committee.

K. Upon closing of the Transaction and the constitution of the Newco Board, the existing Wellmont and Mountain States Boards may be delegated certain responsibilities by the Newco Board, such as credentialing,

	subsidiary and joint-venture oversight, and implementation of Newco Board decisions as required to transition to one governance structure. It is anticipated that the Wellmont Board and Mountain States Board will be dissolved at such time that the Newco Board makes the decision to do so, but not later than 24 months after the closing of the Transaction, with their functions, authority and responsibilities transferred to the Newco Board and its Committees. It is also anticipated that during the transition period between closing and dissolution of each board, the existing Wellmont Board and Mountain States Board will have delegated responsibility for the following: 1. Medical staff credentialing and oversight as those functions currently are outlined in each organization's bylaws; 2. Official business of any subsidiary corporation subject to Newco Board's final authority as sole Member over such decisions; and 3. Regulatory oversight such as those requirements contained within the accreditation standards for hospitals and all other subsidiary services.
IV. **Governance - Board Subcommittees**	A. Board committees will also be established with initial membership of equal representation by and from the Parties. B. Likely committees will include: Executive, Audit; Finance; Legal/ Regulatory/Compliance; Quality; Human Resources; Governance; Investments; and Nominating. C. The final committee structure, committee charters, initial membership, and initial chairs of each will be mutually agreed upon and defined in the Definitive Agreement. D. The Executive Chairman/President of Newco will be an ex-officio, non-voting member of the Nominating Committee. The Nominating Committee charter will establish the criteria for selecting future board and committee members.
V. **Supermajority Items**	A. For a period of time post-Transaction, not to exceed two (2) years, certain board actions will require approval by a supermajority (defined as two-thirds) vote. B. The specific list of actions requiring supermajority approval will be identified in the Definitive Agreement, but will include the following: 1. Amendments to Newco charter and bylaws; 2. Sale of substantially all of the assets of Newco, or merger of Newco with or into another entity; 3. Sale or closure of any hospital; 4. Debt incurrence above an amount to be set forth in the Newco bylaws; 5. Decision to file bankruptcy or insolvency proceedings or to seek

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

	Integration Council who shall be physicians, with two (2) representatives from each of Wellmont and Mountain States. At least one (1) of each health system's physician representatives on the Integration Council shall be a physician in independent practice from each system. C. Wellmont and Mountain States may jointly engage additional third party consultants to advise the Integration Council, as needed. D. After the execution of this term sheet or similar legal document and until the Transaction closing date, the Integration Council will report to the Joint Board Task Force, to be comprised of existing Wellmont and Mountain States Board members, and the CEOs of Wellmont and Mountain States, acting in a transaction committee role. E. All of the activities of the Integration Council prior to Transaction close shall be reviewed and advised in advance by legal counsel to ensure compliance with all applicable legal and regulatory restrictions. F. The Integration Council shall develop a draft Newco policy outlining the process for consolidating services and facilities, which policy shall include but not be limited to cultural integration, timetables for actions, input from physicians impacted, and notices to staff and community. The draft policy shall be submitted to the Newco board for approval. Post-Transaction, the Integration Council will cease operations and its functions shall be assumed by the Newco management team. G. The Parties will mutually agree and define in the Definitive Agreement the ongoing activities, terms of service and scope of the Integration Council within Newco post-Transaction.
VIII. **Clinical Council**	A. Promptly after the Transaction closing, Newco commits to the development of a physician-led Clinical Council (composed of appropriate balances of private physicians, group practice physicians and employed physicians) to guide, oversee and assist in implementation of the plan to integrate clinical activities, service lines and business units, and to advise on any appropriate further clinical integrative actions post-implementation that would result in added growth, operational efficiencies and advancements in patient care. Post-closing, the initial Clinical Council will equally represent physicians whose primary practice venue is Wellmont or Mountain States. B. The Clinical Council will include Newco management representatives but will be composed primarily of physician representatives. The Clinical Council will report to the Chief Medical Officer of Newco. The Chair of the Clinical Council will be a physician member of the active medical staff(s) of one or more Newco-affiliated hospitals, will serve on the Quality Committee of the Newco Board, and will provide ongoing reports on the activities of the Clinical Council to the Newco Board through the Quality Committee function of the Board. 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
IX. **Newco Management**	A. The initial management team ("Initial Management Team") of Newco shall be as follows: • Executive Chairman/President: Alan Levine o The Executive Chairman/President will be the senior officer of the organization. The evaluation of the Executive Chairman/President's performance will reside with the Newco Board. • Chief Executive Officer: Bart Hove o The Chief Executive officer will report to the Executive Chairman/President. • Chief Operating Officer: Marvin Eichorn o The Chief Operating Officer will report to the Chief Executive Officer. • Chief Financial Officer: Alice Pope o The Chief Financial Officer will report to the Chief Executive Officer. The position description for the Executive Chairman/President shall be substantially similar to the position description attached as Exhibit C to this Term Sheet and ensure the position is the most senior officer of Newco. The Joint Board Task Force will develop and approve the Executive Chairman/President's contract for inclusion as an exhibit to the Definitive Agreement, and to be executed by the Newco Board upon the closing of the Transaction • Concurrently with the process for development of the Contract with the Executive Chairman/President, the Executive Chairman/President shall, on behalf of the Joint Board Task Force, negotiate an employment agreement with the Chief Executive Officer for ratification by the Joint Board Task Force. This contract will be included as an exhibit to the Definitive Agreement, and will be executed by the Executive Chairman/President and Chief Executive Officer upon the closing of the Transaction. The position description for the Chief Executive Officer shall be substantially similar to the position description attached as Exhibit D to this Term Sheet. • The Chief Executive Officer, in consultation with the Executive Chairman/President, will then develop job descriptions for the remaining Initial Management Team members for inclusion as an exhibit to the Definitive Agreement. B. The Executive Chairman/President and the Chief Executive Officer of

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

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

	assessment in order to identify and prioritize measurable health needs and initiatives. Such initiatives may include, but not be limited to: • The establishment of a long-term strategy for improving the health status of the region served by the merged system that supports both the Tennessee and Virginia state health plans; • Improvement of behavioral health services, mental health, addiction recovery, and services for people with developmental disabilities; • Enhancement of programs to reduce drug abuse in the region, specifically among women in child-bearing years; • Establishment of programs to improve health literacy; • Development of programs to improve child wellness – physical and emotional; • Growth of medical research programs; and • Expansion of academic opportunities, to include, but not be limited to, expansion of new fellowships and other opportunities to allow physicians and allied health professionals to train and serve in health professional shortage areas within the region. D. Newco will abide by policies and provisions of charity care that are no less generous than the policies of the Parties at the time of the Transaction closing, subject to changes in law, policy or regulation as applicable.
XVII. **Naming/ Branding**	A. The Parties will work to mutually agree to the renaming and rebranding of Newco. Upon signing of this term sheet, Wellmont and Mountain States will mutually agree upon and jointly retain a firm to advise and assist them with the rebranding strategy. The rebranding strategy will have goals of establishing a single identity for the merged system that communicates its mission and clearly informs all members of the regional community of the new name, logo(s), and the mission of the merged system.
XVIII. **Approvals; Termination**	A. The execution and delivery of the Definitive Agreement are conditioned on the receipt of all necessary consents and approvals of the appropriate governing boards of Mountain States and Wellmont. Furthermore, it is anticipated that the Definitive Agreement will provide that the consummation of the Transaction will be conditioned upon: 1. The receipt of all material consents of third parties, if any, necessary under material agreements of the Parties for consummation of the Transaction contemplated under the Definitive Agreement; 2. The filing of all notices and the receipt of all approvals and consents, as required from governmental authorities (including, if applicable, the Attorneys General of the States of Tennessee and Virginia); 3. The termination of any waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; and

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

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

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

(signatures on the following page)

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

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Barbara Allen
Chair

By: _____
Alan Levine
President and CEO

WELLMONT HEALTH SYSTEM

By: _____
Roger Leonard
Chairman

By: _____
Bart Hove
President and CEO

COPY

Exhibit A

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 B

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Description of the Vice Chair/Lead Independent Director Position

Charter of the Vice Chair/Lead Independent Director

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

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

Presides at Executive Sessions

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

Calls Meetings of Independent Directors

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

Conducts Evaluation of Executive Chairman/President

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

Functions as Liaison with the Executive Chairman/President

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

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

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

Authorizes Retention of Outside Advisors and Consultants

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

Constituent Communication

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

Exhibit C

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Description of the Executive Chairman/President Position

Executive Chairman/President

Leadership

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

Meeting

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

Directors

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

Induction, Development and Performance Evaluation

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

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

Relations with Stakeholders

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

Direct Reports

The direct reports to the Executive Chairman/President include:

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

Other Responsibilities

The Executive Chairman/President shall:

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

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

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

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

Exhibit D

COPY

Description of the Chief Executive Officer Position

Chief Executive Officer

Leadership

- The Chief Executive Officer of Newco reports to the Executive Chairman/President and is the senior executive in charge of all business operations of the Newco organization. This executive position requires a combination of operational excellence and system administrative skills and must be attentive to enhanced financial performance in a physician-empowered culture. It is expected that the CEO is adroit in physician relations, physician recruitment and retention.

- This position requires visionary leadership and plays a vital role in creating, implementing and executing the strategy in conjunction with the Executive Chairman/President. Of paramount importance, this position requires the incumbent to establish credibility with employees, physicians, payors, providers and community leaders. The CEO is expected to raise the health system's visibility and reputation in the communities it serves in conjunction with the Executive Chairman/President.

- The CEO position serves as the principal operational leader for the organization and is responsible for driving forward Newco's vision to be the best healthcare delivery system in the region in conjunction with the Executive Chairman/President. This position is the champion for Newco's continued emphasis on "systemness" across the care delivery continuum, to achieve not only its quality and safety goals, but also to increase operational efficiency and provide a consistent point of service contact for its patients.

Major Responsibilities

- Possess a professional and personal adherence to the values, mission and philosophy of the Newco organization.

- Expand on the legacy of the quality and safety of patient care services across the system.

- Working closely with the Executive Chairman/President to lead the ongoing review of the current strategic plan and development of future strategic plans; ensure the plan supports the organization's goal of clinical excellence, while at the same time considers the appropriate business model for the medical staff and strategic service opportunities for growth and addresses revenue generation to sustain ongoing growth. Realize the goal of an integrated health system that leverages the advantages of a multi-state and multimarket health.

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

Direct Reports

- Chief Operating Officer
- Chief Financial Officer

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

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

Exhibit 7

Interim Parent Company Articles

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

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Newco, Inc.
STE 800
211 COMMERCE ST
NASHVILLE, TN 37201-1817

September 11, 2015

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**000814276**	Formation Locale:	TENNESSEE
Filing Type:	Nonprofit Corporation - Domestic	Date Formed:	09/11/2015
Filing Date:	09/11/2015 3:14 PM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2016
Duration Term:	Perpetual	Image # :	B0126-8290
Public/Mutual Benefit:	Public		
Business County:	DAVIDSON COUNTY		

Document Receipt

Receipt # : 002230945	Filing Fee:	$100.00
Payment-Check/MO - BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, NASHVILI		$100.00

Registered Agent Address:
CLAIRE C. HALTOM
STE 800
211 COMMERCE ST
NASHVILLE, TN 37201-1817

Principal Address:
STE 800
211 COMMERCE ST
NASHVILLE, TN 37201-1817

Congratulations on the successful filing of your **Charter** for **Newco, Inc.** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and recieve it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Kelli Wiggins

FILED

ARTICLES OF INCORPORATION

OF

NEWCO, INC.

The undersigned nonprofit corporation acting pursuant to the provisions of the Tennessee Nonprofit Corporation Act, Tennessee Code Annotated, Section 48-51-101, et seq. (the "Act"), adopts the following Articles of Incorporation pursuant to Tennessee Code Annotated, Section 48-52-102:

ARTICLE I.

CORPORATE NAME

The name of the corporation is Newco, Inc. (the "Corporation").

ARTICLE II.

TYPE OF CORPORATION

The Corporation is a public benefit corporation.

ARTICLE III.

INCORPORATOR

The name, address and zip code of the incorporator is Claire C. Haltom, 211 Commerce Street, Suite 800, Nashville, TN 37201.

ARTICLE IV.

REGISTERED AGENT AND OFFICE

The registered office of the Corporation is 211 Commerce Street, Suite 800, Nashville, Tennessee 37201, Davidson County, and its registered agent at that address is Claire C. Haltom.

ARTICLE V.

PRINCIPAL OFFICE

The street address and zip code of the principal office of the Corporation is 211 Commerce Street, Suite 800, Nashville, Tennessee 37201.

ARTICLE VI.

NONPROFIT STATUS

The Corporation is not for profit.

ARTICLE VII.

MEMBERS

The Corporation will not have members.

ARTICLE VIII.

PURPOSES

The purposes for which this Corporation is organized are as follows:

(a) It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, including any amendments that may be made from time to time (the "Code"), and that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code. The Corporation is organized and will be operated exclusively for charitable, scientific, and educational purposes within the meaning Section 501(c)(3) of the Code, including the business of developing, owning and operating inpatient hospitals, clinics, physician practices, other healthcare services, and other services, businesses and activities for the overall purpose of promoting health and providing quality health care services to a broad cross section of the community. In accomplishment of such purposes, the Corporation shall be organized, and at all times operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the not for profit corporations of which it is a member, provided that such not for profit corporations (i) qualify at all times as organizations exempt from federal income tax under Section 501(c)(3) of the Code and (ii) are described in Section 509(a)(1) or 509(a)(2) of the Code.

(b) Notwithstanding the other provisions of these Articles of Incorporation, the Corporation shall only conduct or carry on activities permitted to be conducted or carried on by an organization exempt under Section 501(c)(3) of the Code, and by any organization contributions to which are deductible under Section 170(c)(2) of the Code.

(c) The Corporation may do any and all things hereinabove set forth, and all things usual, necessary or proper in furtherance of or incidental to the purposes of the Corporation.

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2831265-000041 09/11/2015

ARTICLE IX.

LIMITATIONS ON POWERS

As a means of accomplishing the purposes for which it is organized, the Corporation shall have the rights and powers now or later conferred upon corporations not for profit by the Act and the laws of the State of Tennessee, limited in certain respects as follows:

(a) The Corporation shall neither have nor exercise any power, nor shall it directly or indirectly engage in any activity, that would (1) prevent it from obtaining and maintaining exemption from federal income taxation as a corporation described in Section 501(c)(3) of the Code, (2) prevent it from obtaining and maintaining the status of a corporation contributions to which are deductible under Section 170(c)(2) of the Code, or (3) cause it to lose such exemption or status.

(b) The Corporation shall not be operated for the primary purpose of carrying on a trade or business for profit.

(c) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its directors, officers, or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its corporate purposes.

(d) Except as may be permitted from time to time under Section 501 of the Internal Revenue Code, no substantial part of the activities of the Corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation; nor shall it in any manner or to any extent participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office; nor shall the Corporation engage in any activities that are unlawful under applicable federal, state, or local laws.

ARTICLE X.

LIMITATION OF DIRECTOR LIABILITY

To the fullest extent that the laws of the State of Tennessee as it exists on the date hereof permits the limitation or elimination of the liability of directors, no director of the Corporation shall be personally liable to the Corporation for monetary damages for breach of fiduciary duty as a director. If the Act is amended after approval of these Articles of Incorporation to authorize corporate action further eliminating or limiting personal liability of directors, then the liability of a director of the Corporation shall be eliminated or limited to the fullest extent permitted by the Act, as amended, without the requirement for further amendment of these Articles of Incorporation.

ARTICLE XI.

DISSOLUTION

Upon the dissolution of the Corporation, and pursuant to the laws of the State of Tennessee:

(a) All liabilities and obligations of the Corporation shall be paid and discharged, or adequate provisions shall be made therefore; and

(b) All remaining assets of the Corporation shall be distributed to one or more charitable, scientific, literary or educational organizations which are not for profit, and which qualify under the provisions of Section 501(c)(3) of the Code, and which, if practical, are engaged in affairs substantially similar to those of the Corporation, or to the State of Tennessee or any governmental subdivision thereof exclusively for public purposes all as shall be determined by the Board of Directors of the Corporation. In default of any such determination, all remaining assets shall be disposed of by a court of competent jurisdiction in the county in which the principal office of the Corporation is then located exclusively for charitable, scientific, literary, or educational purposes, or to one or more organizations that are organized and operated exclusively for such purposes, as such court determines.

CERTIFICATION

IN WITNESS WHEREOF, these Articles of Incorporation are hereby executed and filed with the Secretary of State of the State of Tennessee, as of September 11, 2015, to be effective immediately.

Claire C. Haltom, Incorporator

Exhibit 8

Interim Parent Company Bylaws

BYLAWS

OF

NEWCO, INC.

ARTICLE I
NAME, PURPOSE, AND PRINCIPAL PLACE OF BUSINESS

Section 1. **Name.** The name of this Corporation is Newco, Inc. (hereinafter referred to as the "Corporation").

Section 2. **Purposes**. It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, including any amendments that may be made from time to time (the "Code"), and that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code. The Corporation is organized and will be operated exclusively for charitable, scientific, and educational purposes within the meaning Section 501(c)(3) of the Code, including the business of developing, owning and operating inpatient hospitals, clinics, physician practices, other healthcare services, and other services, businesses and activities for the overall purpose of promoting health and providing quality health care services to a broad cross section of the community. In accomplishment of such purposes, the Corporation shall be organized, and at all times operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the not for profit corporations of which it is a member, provided that such not for profit corporations (i) qualify at all times as organizations exempt from federal income tax under Section 501(c)(3) of the Code and (ii) are described in Section 509(a)(1) or 509(a)(2) of the Code.

ARTICLE II
MEMBERS

The Corporation shall have no members.

ARTICLE III
BOARD OF DIRECTORS

Section 1. **Duties**. The business and affairs of the Corporation shall be governed exclusively by its Board of Directors. The Board of Directors shall be responsible for ensuring high quality delivery of health care and human services to the communities served by the Corporation and the Corporation's subsidiaries. The Board of Directors may delegate certain authorities to subsidiary boards. Any authorities not specifically delegated are reserved to the Board of Directors of the Corporation.

Section 2. **Composition**. The Corporation's Board of Directors shall consist of four (4) directors, two (2) of whom shall be appointed by Mountain States Health Alliance, ("MSHA"), and two (2) of whom shall be appointed by Wellmont Health System ("Wellmont"); provided, however, that all Directors shall be persons who are deemed to be independent community directors in accordance with Internal Revenue Service guidance for organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers; provided, further, in order to satisfy the requirements for an organization supervised or controlled in connection with organizations described in Code Section 509(a)(1) or (2), as

described in Code Section 509(a)(3)(B)(ii), at all times all of the Corporation's directors will also be directors of MHSA and directors of Wellmont.

Section 3. Terms.

The Directors shall serve for a term of two (2) years commencing immediately following his or her respective appointment and continuing until their respective successors shall have been appointed and qualified.

Section 4. Vacancies. Vacancies arising in positions on the Board of Directors (whether by resignation, death, expiration of term of office, termination, removal, increase in Board size, or other reason) shall be filled by the corporation which appointed the Director vacating the position.

Section 5. Removal. Directors may be removed without cause by the corporation which appointed the Director to be removed.

Section 6. Resignation. A director may resign at any time by delivering written notice of resignation to the Corporation's Secretary. Resignation is effective when notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

Section 7. Confidentiality and Fiduciary Duty of Loyalty, Care and Obedience.. Each director shall maintain the strict confidentiality of all information discussed or received in connection with any meeting of the Board of Directors and any committee meeting, whether such information is oral, written or preserved in any other form. No Director shall use any information gained through or in connection with his or her capacity as a director in any manner which might create, directly or indirectly, any form of personal benefit unless such usage is consistent with and done in compliance with the Corporation's policies regarding Conflicts of Interest. Each Director shall, at all times, exercise loyalty, care and obedience to the fiduciary responsibilities entrusted to the Director on behalf of the Corporation.

ARTICLE IV
OFFICERS OF THE CORPORATION

Section 1. Officers. The officers of the Corporation shall consist of a President, a Secretary, and a Treasurer. Except as provided below, all officers of the Corporation shall be elected by, and shall serve at the pleasure of, the Board of Directors. A duly appointed officer may appoint one (1) or more officers or assistant officers.

Section 2. Resignation. An officer may resign at any time by delivering written notice of resignation to the Corporation's President or Secretary. Resignation is effective when the notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

ARTICLE V
POWERS AND DUTIES OF THE OFFICERS.

Section 1. **President**. Subject to the oversight of the Board of Directors, the President of the Corporation shall have general supervision, direction and control of the business and affairs of the Corporation and shall have the general powers and duties of management usually vested in persons in similar positions. In such capacity, the President shall report to the Board of Directors. The President, or his/her designee, may execute all promissory notes, mortgages, deeds, contracts and other instruments. The President shall have such other duties and authority as may be prescribed elsewhere in these Bylaws or from time to time by the Board of Directors.

Section 2. **Secretary**. The Secretary shall cause to be kept the minutes of all meetings of the Board of Directors and of any committee. He or she shall cause to be given all notices provided for in these Bylaws. He or she shall have custody of the seal of the Corporation and shall affix the same, attested by his or her signature, to all instruments required to be under the seal of the Corporation. He or she shall have the duties, power and responsibilities of the secretary of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

Section 3. **Treasurer**. The Treasurer shall be the official custodian of all funds and securities of the Corporation, and shall deposit, or cause to be deposited, same in such banks or other depositories as the Board of Directors may designate or approve. He or she shall have the duties, power and responsibilities of the treasurer of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

ARTICLE VI
MISCELLANEOUS

Section 1. **Corporate Seal**. The Board of Directors may provide a seal for the Corporation in the form approved by the Board of Directors.

Section 2. **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of July of each year.

ARTICLE VII
NOTICE

Whenever under the provisions of the Act, the Charter, or these Bylaws notice is required to be given to any director, officer, or committee member of the Corporation, it shall not be construed to require personal notice, but such notice, unless required to be in writing, may be given by telephone or electronic mail and, if given in writing, may be given either personally or by facsimile, or by depositing the same in a post office or letter box in a postpaid, sealed wrapper., in either case addressed to such director, officer, or committee member at his or her address as the same appears in the records of the Corporation; and the time when the same shall be so mailed or faxed, shall be deemed to be the time of the giving of such notice.

ARTICLE VIII
INDEMNIFICATION

Section 1. **Indemnification of Officers and Directors**. The Corporation shall indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an officer or director (whether voting or non-voting) of the Corporation against liabilities and expenses incurred in the proceeding to the fullest extent permitted by the Act. The Corporation shall make advances for expenses incurred or to be incurred in the proceeding as provided for in the Act.

Section 2. **Indemnification of Employees and Agents**. The Corporation may indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an employee or agent of the Corporation against liabilities and expenses incurred in the proceeding to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act. The Corporation may make advances for expenses incurred or to be incurred in the proceeding to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act.

Section 3. **Insurance**. The Corporation shall have the power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee, or agent of another Corporation, partnership, joint venture, trust, or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have the power or would be required to indemnify him or her against such liability under the provisions of this Article.

Section 4. **Nonexclusivity**. The rights of indemnification and advancement of expenses granted pursuant to this Article shall not be deemed exclusive of any other rights to which an officer, director, employee, or agent seeking indemnification or advancement of expenses may be entitled, pursuant to the Act, Tennessee statutory or case law, the Corporation's Charter, these Bylaws, a resolution of the Board of Directors, or an agreement or arrangement providing for indemnification; provided, however, that no indemnification may be made to or on behalf of any officer, director, employee, or agent, if a judgment or other final adjudication establishes that such indemnification is prohibited by Section 48-58-502 of the Act or any successor statutory provision.

Section 5. **Statutory Immunities**. Nothing contained in this Article VIII shall be construed to prejudice or otherwise diminish the limitations, immunities and other protections available to the directors and officers of the Corporation (including a director of a Hospital Board) pursuant to Section 48-58-601 of the Act or any successor statutory provision.

ARTICLE IX
CONFLICTS OF INTEREST

The Board of Directors shall adopt and maintain a Conflict of Interest Policy applicable to all members of the Board, Board Committees, officers of the Corporation, and key management personnel. The policy shall require the annual completion and submission of an acknowledgement and disclosure statement, as well as a confidentiality agreement applicable to all business of the Board of Directors.

Exhibit 9

Amended Parent Company Bylaws

AMENDED AND RESTATED

BYLAWS

OF

NEWCO, INC.

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Table of Contents

ARTICLE I
NAME AND PURPOSE,

Section 1. Name. The name of this Corporation is Newco, Inc. (hereinafter referred to as the "Corporation").

Section 2. Purposes. It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, including any amendments that may be made from time to time (the "Code"), and that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code. The Corporation is organized and will be operated exclusively for charitable, scientific, and educational purposes within the meaning Section 501(c)(3) of the Code, including the business of developing, owning and operating inpatient hospitals, clinics, physician practices, other healthcare services, and other services, businesses and activities for the overall purpose of promoting health and providing quality health care services to a broad cross section of the community. In accomplishment of such purposes, the Corporation shall be organized, and at all times operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the not for profit corporations of which it is a member, provided that such not for profit corporations (i) qualify at all times as organizations exempt from federal income tax under Section 501(c)(3) of the Code and (ii) are described in Section 509(a)(1) or 509(a)(2) of the Code.

ARTICLE II
MEMBERS

The Corporation shall have no members.

ARTICLE III
BOARD OF DIRECTORS

Section 1. Duties. The business and affairs of the Corporation shall be governed exclusively by its Board of Directors. The Board of Directors shall be responsible for ensuring high quality delivery of health care and human services to the communities served by the Corporation and the Corporation's subsidiaries, with such responsibilities including, but not being limited to:

(a) the establishment, approval and review of policies necessary for the governance of the Corporation, including delegations of authority, establishment and Board approval of the strategic plan, the provision of quality patient care and the appropriate allocation of personnel, resources and assets;

(b) the establishment, approval and review of policies and procedures, or the appropriate delegation of authority for such policies and procedures, for the effective delivery of healthcare services within the Corporation's affiliated Hospitals and ancillary facilities including appropriate Medical Staff bylaws and competency standards, nursing practice standards, and regulatory standards for care delivery;

(c) the approval of the Corporation's annual operating budget;

(d) the approval of long-term capital expenditure budgets which address the Corporation's anticipated capital needs;

(e) the regular review of the Corporation's financial performance vis-a-vis its annual operating budgets and capital budgets, and the adjustment or modification of such budgets from time to time as circumstances require;

(f) the establishment of policies sustaining performance improvement, risk management and quality programs with appropriate assessment of effectiveness of each program;

(g) the regular review of the Corporation's Corporate Compliance Plan, its implementation, and observance;

(h) the oversight of fulfillment of the community benefit purpose of the Corporation;

(i) at the end of the Integration Period, conduct a review to determine whether retaining the Executive Chair/President and Vice Chair/Lead Independent Director structure, or converting to an independent Chair and Chief Executive Officer structure, is necessary or desirable in the best interest of the Corporation and its mission and purpose.

The Board of Directors may delegate certain authorities to subsidiary boards. Any authorities not specifically delegated are reserved to the Board of Directors of the Corporation.

The Board of Directors, in fulfilling its governance role, will ensure meaningful participation by management, clinical and physician leadership and any advisors deemed appropriate by the Board of Directors. The Board of Directors shall require the implementation of such systems and procedures as will foster effective communication by and among the administrative and departmental staffs, the Medical Staffs, and the Board of Directors.

At least one (1) time each fiscal year, the Board of Directors shall meet to assess the performance of the Board of Directors and the Corporation's progress toward executing its strategic plan and achieving its stated goals and objectives. Where appropriate, such review process shall include an assessment and adjustment of the Corporation's long-range, strategic, and operational plans and policies, as well as the Corporation's budget, fiscal position, and allocation of resources, in light of the Corporation's stated business purposes and mission statement.

(j) **Composition (Integration Period)**. During the Integration Period, the Corporation's Board of Directors shall consist of not more than seventeen (17) voting directors, sixteen (16) of whom shall be appointed on the Closing Date. Two of the voting directors shall be the Executive Chair/President of the Corporation and the Chief Executive Officer of the Corporation, each of whom who shall serve as a voting ex-officio director, subject in the case of the Chief Executive Officer, to the limitations in Sections 2 and 3 below. The voting directors who are not serving ex officio shall be and are divided into two (2) Category J Directors, six (6) Category W Directors and six (6) Category M Directors. The voting directors who are not serving ex officio shall be and are divided further into three classes, designated Class I, Class II and Class III. Class I and Class II initially each shall consist of two (2) Category M Directors and two (2) Category W Directors. Class III initially shall consist of two (2) Category J Directors, two (2) Category M Directors, and two (2) Category W Directors. At least two (2) Category M Directors and two (2) Category W Directors shall be physicians who are members of the active medical staff of at least one of the

Corporation's affiliated Hospitals; provided, however, that, at all times, the majority of the Board of Directors shall consist of members who are deemed to be independent community directors in accordance with Internal Revenue Service guidance for organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers; provided, further, in order to satisfy the requirements for an organization supervised or controlled in connection with organizations described in Code Section 509(a)(1) or (2), as described in Code Section 509(a)(3)(B)(ii), at all times all of the Corporation's directors will also be directors of Mountain States Health Alliance and directors of Wellmont Health System. In addition, the person serving from time to time as the President of East Tennessee State University shall serve as a non-voting ex-officio director.

(k) **Composition (Post-Integration Period)**. Except for the purposes of Section 3(b)(ii) below, upon the expiration of the Integration Period the division of the Board of Directors into Categories J, M and W shall cease, but the terms and the designation into Classes of the persons then serving as Directors shall not be affected thereby. After the expiration of the Integration Period the Corporation's Board of Directors shall consist of not more than seventeen (17) voting directors, one of whom shall be the Executive Chair/President of the Corporation who shall serve as a voting ex-officio director. The sixteen (16) voting directors who are not serving ex officio shall be and are divided into three classes, designated: Class I, Class II and Class III; provided, in order to satisfy the requirements for an organization supervised or controlled in connection with organizations described in Code Section 509(a)(1) or (2), as described in Code Section 509(a)(3)(B)(ii), at all times all of the Corporation's directors will also be directors of Mountain States Health Alliance and directors of Wellmont Health System. In addition, the person serving from time to time as the President of East Tennessee State University shall serve as a non-voting ex-officio director.

(l) **Qualifications.** In the selection of directors, appropriate consideration shall be given to an individual's competencies, skills and perspectives and the individual's ability to commit the time necessary to devote to a director's duties. Consideration shall also be given to the inclusion of a variety of business, health-related, and consumer perspectives among the various members of the Board of Directors, with a goal of achieving (i) a geographic and demographic diversity among the members and (ii) a mix of competencies, skills and perspectives as determined by the Board from time to time to be necessary or desirable

(m) **Orientation.** The Board shall adopt a policy ensuring appropriate orientation of new Board and Board Committee members.

(n) **Additional Independent Director.** During the Integration Period, the Board of Directors may choose to elect a person to serve as the Additional Independent Director, who may be in addition to the sixteen (16) persons appointed on the Closing Date. If elected, the Additional Independent Director will be a Category J Director and appointed to Class III.

Section 2. Terms.

Generally, each director shall serve for a term of three (3) years ending on the date of the third annual meeting of directors following the annual meeting of directors at which such director was elected. For purposes of this section, the Closing Date shall be deemed the date of the initial annual meeting and initial election of directors. Notwithstanding the generally applicable terms of office, each director initially appointed to Class I shall serve for an initial term expiring at the

Corporation's second annual meeting of directors following the Closing Date; each director initially appointed to Class II shall serve for an initial term expiring at the Corporation's third annual meeting of directors following the Closing Date; and each director initially appointed to Class III (including the Additional Independent Director, if elected) shall serve for an initial term expiring at the Corporation's fourth annual meeting of directors following the Closing Date; provided, that the term of each director shall continue until the election and qualification of a successor and be subject to such director's earlier death, resignation or removal. Ex-officio directors shall serve for a term that is commensurate with their term of office in the ex-officio position which creates membership on the Corporation's Board of Directors, except that the Chief Executive Officer of the Corporation shall cease to serve as a voting ex-officio director on the second anniversary of his or her initial appointment.

Elected directors may serve no more than two (2) consecutive three (3) year terms. An initial appointment as a Class I, Class II, or Class III Director shall be deemed a 3-year term for the purpose of this consecutive term limitation.

Section 3. Vacancies.

(a) In General. Except as set forth in subsection (b) of this Section 3, vacancies arising in positions on the Board of Directors (whether by resignation, death, expiration of term of office, termination, removal, increase in Board size, or other reason) shall be filled by the Board of Directors based upon nominations presented by the Governance/Nominating Committee. In submitting its nominations, the Governance/Nominating Committee shall endeavor to propose nominees who possess the skill sets identified in Article III, Section 1 of these Bylaws taking into account the skill mix of the persons then serving on the Board of Directors.

(b) Integration Period and Initial Vacancies.

(i) During the Integration Period, any vacancy among the Category M Directors or Category W Directors shall be filled by a vote of the majority of the remaining Category M or Category W Directors, as the case may be. During the Integration Period, any vacancy among the Category J Directors, including the Additional Independent Director, if nominated by the Governance/Nominating Committee, shall be filled by a person approved by the vote of a majority of each of the Category M Directors and the Category W Directors, voting as two classes.

(ii) Notwithstanding Section 1(k) above, after the Integration Period, and until the fourth anniversary of the closing of the affiliation transaction between Wellmont Health System and Mountain States Health Alliance, any vacancy among the Category M Directors or Category W Directors shall be filled by a vote of the majority of the Board of Directors upon the nomination of a replacement by the remaining Category M or Category W Directors, as the case may be, and shall consider the appropriate competencies determined to be desirable by the Board of Directors.

(iii) The Category W Directors shall appoint, by majority vote, a person to serve as a Class I, Category W Director to replace the Chief Executive Officer of the Corporation when he or she shall cease to serve as a voting ex-officio director as provided in Section 2 above.

(iv) In the event of a separation between the Corporation and the Executive Chair/President during the Integration Period:

A. The Category M Directors shall nominate one Director to serve as the Acting Chair of the Board of Directors, which nominee shall be subject to election by a majority vote of the Board of Directors. The Acting Chair shall assume the powers and responsibilities of the Executive Chair/President as Chair of the Board of Directors and will not have operating responsibilities.

B. The Chief Executive Officer shall immediately become a non-voting ex-officio director.

C. The Board may choose to appoint an interim President to assume the management responsibilities of the Executive Chair/President. The Board shall follow industry best practices in developing a process for selection of a permanent replacement for the Executive Chair/President.

D. The Board shall conduct a review to determine whether retaining the Executive Chair/President and Vice Chair/Lead Independent Director structure, or converting to an independent Chair and Chief Executive Officer structure, is necessary or desirable in the best interest of the Corporation and its mission and purpose.

Section 4. **Removal**. Voting and non-voting directors may be removed by a majority vote (as described below in Section 5) of the Board of Directors only for cause. For purposes of these Bylaws, "for cause" shall mean: (i) failure to satisfy the attendance requirements for directors set forth below in Section 7; (ii) continuous disruptive behavior as determined by the Board of Directors in its reasonable judgment; (iii) conviction of a felony or a crime of moral turpitude; (iv) incapacity, inability, or unwillingness to perform the duties and responsibilities of a director, as determined by the Board of Directors in its reasonable discretion; (v) engagement by a director in an activity, arrangement, or transaction which would result in a material conflict with his or her position as a director of the Corporation or the Corporation's interests or purposes, as determined by the Board of Directors in its reasonable discretion; (vi) a breach of the duty of confidentiality as such duty is set forth below in Section 9, or as such duty may otherwise be provided for or defined from time to time in the Corporation's internal policies or by action of the Board of Directors, or (vii) such other activity, event, or reason determined to constitute cause by the Board of Directors in its reasonable discretion.

Section 5. **Actions of the Board.**

(a) Majority and Super-Majority Votes. Except as otherwise set forth below, actions of the Board of Directors shall require the affirmative vote of a majority of the voting directors at a meeting at which a quorum is present. For purposes of these Bylaws, a quorum of the Board of Directors shall be a majority of the voting directors. Notwithstanding the foregoing, until the second anniversary of the closing of the affiliation transaction between Wellmont Health System and Mountain States Health Alliance, the following actions may be taken by the Board of Directors only upon the affirmative vote of a majority of the directors then in office, which must include a majority of the Category M Directors and a majority of the Category W Directors, each voting as a class (referred to herein as a "super-majority vote"):

(i) Amendments to the Charter or Bylaws of the Corporation, including amendments to the duties of the Executive Chair/President or the Vice Chair/Lead Independent Director as set forth in these Bylaws.

(ii) Sale or closure of any of the Hospitals;

(iii) Adoption of a plan of dissolution for the Corporation;

(iv) Sale or other transfer of all or substantially all of the Corporation's assets;

(v) Entering into a plan of merger or consolidation of the Corporation with or into an unrelated entity;

(vi) Incurrence of any indebtedness, guarantees, or capital lease obligations exceeding $100 million in the aggregate during any fiscal year, other than trade payables and other short-term liabilities in the ordinary course of business;

(vii) Discontinuation of major service lines where any such discontinuation would render the service unavailable in that community.

(viii) Any decision to file a petition requesting or consenting to an order for relief under the federal bankruptcy laws, or other actions with respect to the Corporation or any member of its obligated group as a result of insolvency or the inability to pay debts generally as such debts become due.

Section 6. **Meetings**. The Board of Directors shall hold an annual meeting in the month of June of each year. The Board shall hold regular meetings on not less than a quarterly basis. Special meetings shall be held as called by the Executive Chair/President or the Vice Chair/Lead Independent Director, or as requested by any three (3) directors in writing to the Secretary of the Corporation. Any actions of the Board of Directors to be taken at a meeting may be taken without a meeting if all voting directors consent in writing (which shall include electronic mail) to taking such action without a meeting. Directors may participate in any meeting of the Board of Directors by means of a conference telephone or similar communications equipment through which all persons participating in the meeting can hear each other. Participation by such means shall constitute presence in person at such meeting.

Section 7. **Attendance Requirements**. Each voting director shall be required to attend at least seventy-five percent (75%) of all scheduled meetings during any fiscal year (annual, regular, or special), unless otherwise excused by the Executive Committee. Failure to attend seventy-five percent (75%) of all scheduled meetings or failure to attend three (3) consecutive meetings shall constitute cause for removal as a voting director.

Section 8. **Resignation**. A director may resign at any time by delivering written notice of resignation to the Corporation's Secretary. Resignation is effective when notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

Section 9. **Confidentiality and Fiduciary Duty of Loyalty, Care and Obedience.**. Each director shall maintain the strict confidentiality of all information discussed or received in connection with any meeting of the Board of Directors and any committee meeting, whether such

information is oral, written or preserved in any other form. Unless otherwise expressly authorized by Board action or by the Executive Chair/President, or unless disclosure is otherwise made by the Corporation through authorized action such as approved press releases or public statements, no director shall disclose, discuss or otherwise disseminate any information relating to the actions, deliberations and decisions of the Board of Directors and any committee of the Board of Directors. In any situation where comment or discussion is permitted, such comment or discussion shall extend only so far as is consistent with the degree of authorization. Further, no director shall use any information gained through or in connection with his or her capacity as a director in any manner which might create, directly or indirectly, any form of personal benefit unless such usage is consistent with and done in compliance with the Corporation's policies regarding Conflicts of Interest. Each Director shall, at all times, exercise loyalty, care and obedience to the fiduciary responsibilities entrusted to the Director on behalf of the Corporation. Each director shall execute an annual written acknowledgement of his or her duties of confidentiality, loyalty, care and obedience and such acknowledgements shall be kept in the official records of the Corporation.

ARTICLE IV
OFFICERS OF THE CORPORATION

Section 1. **Officers**. The officers of the Corporation shall consist of an Executive Chair/President, a Vice Chair/Lead Independent Director, a Chief Executive Officer (the "CEO"), a Secretary, a Treasurer, and such officers as the Board of Directors shall elect or appoint. The offices of Executive Chair/President, Vice Chair/Lead Independent Director, Secretary, and Treasurer shall be held by directors (collectively, the "Board Officers").

Section 2. **Terms of Office**. Except for the Executive Chair/President and the CEO, who shall each hold their offices for so long as their employment by the Corporation to serve in those positions continues, the Board Officers shall serve two (2) year terms. A Board Officer may serve no more than two (2) consecutive two (2) year terms in the same office. Nothing contained in these Bylaws shall be construed to constitute a contract of employment. Other than the limitations applicable to Board Officers, there shall be no limit as to the number of consecutive terms corporate officers may serve. Each Board officer shall hold office until his or her successor is duly elected and qualified.

Section 3. **Election, Removal and Vacancies**.

(a) Except as provided below, all officers of the Corporation shall be elected by, and shall serve at the pleasure of, the Board of Directors. Nominations for Board Officer positions shall be submitted by the Governance/Nominating Committee. Nominees for Board Officer positions shall be Directors. Removal of any officer shall be without prejudice to the contract rights, if any, of the officer; provided, however, that election of an officer itself shall not create any contractual rights.

(b) During the Integration Period, the successor to the person serving as the initial Vice Chair/Lead Independent Director shall be nominated by a majority vote of the Category W Directors, and elected by the non-management members of the Board of Directors. The individuals elected to serve as Treasurer and Secretary during the Integration Period shall be elected as follows: one from among the Category W members and one from the Category M members.

Section 4. **Resignation**. An officer may resign at any time by delivering written notice of resignation to the Corporation's Secretary. Resignation is effective when the notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

ARTICLE V
POWERS AND DUTIES OF THE OFFICERS.

Section 1. **Executive Chair/President**. The Executive Chair/President shall have the powers usually vested in the office of Chair of a Board of Directors, the powers usually vested in the office of President of a Corporation, and as the most senior officer of the Corporation, shall have the powers and duties set forth in the written employment agreement entered into by the Corporation with the Executive Chair/President and any amendments thereto. He or she shall preside at all meetings of the Board of Directors, unless he or she is unable to attend. He or she shall see that all orders and resolutions of the Board of Directors are carried into effect. He or she shall perform all other duties required of him or her by the laws of the State of Tennessee. The Board of Directors shall periodically evaluate the performance of the Executive Chair/President in the context of the Corporation's progress toward and attainment of the Corporation's strategic and business goals and objectives as established from time to time by the Board. The Executive Committee, or another committee specifically appointed by the Board, shall conduct such performance reviews. The Executive Chair/President shall, at least annually, evaluate the performance of the CEO and the other officers reporting to him or her.

Section 2. **Vice Chair/Lead Independent Director**. In the absence or disability of the Executive Chair/President, the Vice Chair/Lead Independent Director shall exercise only those powers and shall perform only the duties of the Executive Chair/President with respect to the Executive Chair/President's role as the Chair of the Board of Directors, and not any of the powers and duties of the Executive Chair/President as the President and most senior officer the Corporation. Additionally, he or she shall have the duties set forth in Exhibit A attached hereto.

Section 3. **Chief Executive Officer**. The Chief Executive Officer (the "CEO") shall be appointed by Executive Chair/President. Any employment agreement with respect to the CEO shall be ratified by a majority vote of the Board of Directors. The Chief Executive Officer will report to the Executive Chair/President and shall have the powers and duties set forth in the written employment agreement entered into by the Corporation with the Chief Executive Officer and any amendments thereto. The CEO shall, at least annually, evaluate the performance of the officers reporting to him or her.

Section 4. **Vice Presidents**. To the extent any Vice President is to act as an officer of the Corporation, the Board of Directors shall confirm such responsibilities as an officer of the Corporation through resolution or other form of approval. Each such Vice President shall be responsible for executing and carrying out such duties, instructions, objectives and orders as may be established by the Executive Chair/President or CEO from time to time.

Section 5. **Secretary**. The Secretary shall cause to be kept the minutes of all meetings of the Board of Directors and of the Executive Committee. He or she shall cause to be given all notices provided for in these Bylaws. He or she shall have custody of the seal of the Corporation and shall affix the same, attested by his or her signature, to all instruments required to be under the seal of the Corporation. He or she shall have the duties, power and responsibilities of the secretary

of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

Section 6. **Treasurer**. The Treasurer shall be the official custodian of all funds and securities of the Corporation, and shall deposit, or cause to be deposited, same in such banks or other depositories as the Board of Directors may designate or approve. He or she shall have the duties, power and responsibilities of the treasurer of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

ARTICLE VI
SIGNATURE AND ENDORSEMENTS OF NOTES, CHECKS, ETC.

Section 1. **Signatures**. All notes, checks, bonds, and other promises to pay money shall be signed by an officer or other individual authorized by the Board of Directors.

Section 2. **Endorsements and Sales of Securities**. Checks, drafts, notes, and other negotiable instruments payable to the Corporation or to its order shall be endorsed for collection or deposit by an officer or other individual authorized by the Board of Directors. Stocks, bonds, or other securities owned by the Corporation may be sold or transferred upon signature of an officer or other individual authorized by the Board of Directors.

ARTICLE VII
COMMITTEES

Section 1. **Designation**. The Board of Directors may, from time to time, establish such standing and special committees as it deems advisable and in the best interests of the Corporation. All committee actions are advisory to the Board of Directors, unless the Board of Directors, through resolution, has delegated any authority to a committee it deems advisable; provided, however, that no committee may:

(a) Take any action required by Article III, Section 6, to be taken by a super-majority vote of the Board of Directors;

(b) Authorize distributions; or

(c) Elect, appoint, or remove directors or fill vacancies on the Board of Directors or any committee thereof.

Section 2. **Committee Members**. Other than members of the Executive Committee, whose members shall be members of the Board of Directors, Board committees may be composed of non-directors. Members of a committee may be designated as voting or non-voting ex-officio members. The Executive Chair/President shall recommend committee members, and presiding officers/chairs, for standing committees annually for consideration by the Governance/Nominating Committee. The Governance/Nominating Committee shall consider the recommendations of the Executive Chair/President, and make nominations to the Board of Directors, which shall, by majority vote, elect the committee membership. Each committee member shall serve for a one (1) year term, or on such other basis and for such other terms as set forth by the Board of Directors. The Board of Directors may remove any committee member with or without cause. Vacancies on a committee, due to death, resignation, expiration of term, or removal shall be filled by the Board of

Directors in the manner prescribed in this section. Committee members shall serve until their successors are duly elected and qualified. For the initial committee appointments, the Governance/Nominating Committee shall ensure equal numbers of individuals from existing committees of the Boards of Directors of Wellmont Health Systems and Mountain States Health Alliance. For purposes of this section, initial committee appointments shall mean only the first appointment of the individual selected to serve upon the Closing Date and shall not apply to any vacancies thereafter.

Section 3. **Voting and Quorum Requirements**. Except as otherwise limited by the Board of Directors, all actions of a committee shall require the affirmative vote of a majority of the voting members of the committee at a meeting at which a quorum is present. A majority of the voting members shall constitute a quorum. Any actions of a committee to be taken at a meeting may be taken without a meeting if all voting members of the committee consent in writing, to include electronic mail, to taking such action without a meeting. Members may participate in any meeting of the Committee by means of a conference telephone or similar communications equipment through which all persons participating in the meeting can hear each other. Participation by such means shall constitute presence in person at such meeting. Each Committee shall hold such meetings as it deems appropriate, or as directed by the Board. Each Committee member shall be required to attend seventy-five percent (75%) of all scheduled meetings (regular or special) during any fiscal year, unless otherwise excused by the chair of the Committee. Failure to attend seventy-five percent (75%) of all scheduled meetings or three (3) consecutive scheduled meetings shall constitute cause for removal as a member of such Committee.

Section 4. **Standing Committees**. The Corporation's Board of Directors shall have the following standing committees: Executive; Audit and Compliance; Finance; Quality, Service and Safety, Executive Compensation, Community Benefit, Workforce and Governance/Nominating. The Board of Directors may establish such other committees as it deems necessary or appropriate from time to time. Committee Chairs shall be members of the Board of Directors. The Executive Chair/President and CEO may not serve as Chair of standing committees, except that as provided in subsection (a)(i) below the Executive Chair/President shall serve as the presiding officer of the Executive Committee. Non-voting ex-officio members may serve as Committee Chairs upon the conclusion of the Integration Period. Each standing committee and any committee created by the Board of Directors shall establish and maintain a charter describing its duties in detail, shall regularly review and propose revisions to its charter in light of industry best practices, and shall present such charter and any proposed revisions for review and approval by the Board of Directors.

(a) **Executive Committee**.

(i) **Composition**. The Executive Committee shall be comprised of both voting and non- voting members. The voting members shall be the Executive Chair/President, the Vice Chair/Lead Independent Director, the Treasurer, and the Secretary of the Corporation, and two at-large members. The CEO of the Corporation shall be a non-voting ex-officio member of the Executive Committee. The Executive Chair/President shall serve as the presiding officer of the Executive Committee. The initial at-large members of the Executive Committee serving during the Integration Period shall be one Class W Director and one Class M Director.

(ii) **Powers and Duties**. The Executive Committee shall have and exercise the full authority and have all the powers and duties of the Board of Directors except as otherwise limited by the Act, the Board of Directors, or these Bylaws. The Executive Committee may

transact the business of the Corporation in urgent situations during the periods between meetings of the Board of Directors; provided that any action taken shall not conflict with the policies and expressed wishes of the Board of Directors. Matters of major importance shall be referred to the entire Board of Directors unless the urgency of the situation does not permit delay. The Executive Committee shall report any action taken between meetings to the Board of Directors as soon as practicable.

(iii) **Review of Executive Chair/President.** The Executive Committee, or another committee as expressly determined by the Board of Directors, is charged with the responsibility of evaluating the Executive Chair/President. The Executive Compensation Committee shall be charged with the responsibility of approving the compensation of the Executive Chair/President. The Executive Committee shall provide its evaluation of the Executive Chair/President to the Executive Compensation Committee for its consideration, in addition to any other factors considered by the latter , in setting compensation of the Executive Chair/President. The Lead Independent Director shall ensure a mechanism is established for input by the full Board of Directors on the evaluation of the Executive Chair/President, and that feedback is provided to the Executive Chair/President. As it relates to his or her compensation or performance evaluation, the Executive Chair/President shall not participate in the evaluative deliberations of the Executive Committee or the Executive Compensation Committee other than to provide information, answer questions and receive feedback.

(b) **Audit and Compliance Committee**. The Audit and Compliance Committee shall: (a) ensure the integrity of the Corporation's financial reporting and audit procedures, including engagement of an independent public accounting firm to conduct an annual certified audit and examination of the Corporation's financial reporting and controls; (b) ensure financial controls are adequate to protect the integrity of the Corporation's financial assets; (c) report, as needed, to the Board of Directors, any issues related to financial controls and recommend any changes deemed necessary by the committee; (d) monitor the Corporation's compliance program and make any recommendations related to compliance risk and (e) approve the compliance policies. The Corporation's Chief Compliance Officer and Senior Audit Director shall report jointly to the Executive Chair/President and to the Audit and Compliance Committee, and any reports shall be provided to both. The Audit Committee shall be comprised of membership that includes individuals with audit and public accounting experience. The Governance/Nominating Committee shall seek to nominate a Chair of the Audit and Compliance Committee who is experienced in accounting and audit oversight, subject to the requirement that committee chairs must be members of the Board of Directors. The membership of the Audit and Compliance Committee shall be constituted by individuals who are independent as defined by the IRS Form 990.

(c) **Finance Committee**. The primary responsibilities of the Finance Committee are to develop and recommend operating and capital budgets to the Board of Directors, and to monitor the ongoing financial performance of the Corporation.

(d) **Quality, Service and Safety Committee**.

(i) The Board of Directors has the ultimate responsibility for quality patient care and authority for maintaining a Performance Improvement and Risk Management Program. The Board of Directors may delegate certain functions of this program to the Executive Chair/President, or to the respective community boards of each hospital (the " Community Boards"), together with the authority for action under limitations described in this section. The Quality, Service and Safety

Committee is charged with the responsibility of ensuring these functions are administered, and reporting to the Board of Directors.

A. The Quality, Service and Safety Committee shall require the medical staffs and staffs of the various departments/services of the hospitals to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care.

B. The Board of Directors, through the Quality, Service and Safety Committee, the Executive Chair/President and CEO, shall fully support performance improvement activities and mechanisms. The Board, through the Executive Chair/President, shall also provide for adequate resources and support systems for the performance improvement functions related to patient care and safety.

C. The Quality, Service and Safety Committee shall assess the effectiveness of the performance improvement program on an annual basis, and shall re-endorse or recommend revisions to the program as necessary. These recommendations shall be made to the Board of Directors, which shall timely consider the recommendations, and either endorse or make changes to the program.

(ii) The Medical Staffs of the various affiliated hospitals, through their elected officers, departments, committees, and individual members shall make a commitment to actively participate in the performance improvement program by developing indicators to be used for screening, evaluating and utilizing clinical judgment concerning identified problems or opportunities to improve care. Findings shall be reported to the Board of Directors through the Quality, Service and Safety Committee. Priority shall be given to those aspects of care which are high-volume, high-risk or problem-prone.

A. Department Chairmen are responsible for assuring the implementation of a planned and systemic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the departments and the clinical performance of all individuals with clinical privileges in those departments. When important problems in patient care and clinical performance or opportunities to improve care are identified, action shall be taken and the effectiveness of such action taken evaluated.

B. The presidents of the respective medical staffs shall facilitate and coordinate medical staff involvement in the performance improvement program and shall serve as advisor to the respective Community Board on performance improvement matters.

C. The respective Community Boards may delegate oversight of the hospital-wide performance improvement program as it pertains to the medical staff to the executive committee of the medical staff.

(iii) The Executive Chair/President, through the CEO, is responsible for implementation of the performance improvement program as it concerns non-physician professionals and technical staff and patient care units. The Executive Chair/President shall actively support the performance improvement program by the provision of adequate resources.

(iv) The Executive Chair/President may delegate necessary functions to the CEO to ensure, system-wide, that all functions related to performance improvement, risk management and improvement in the clinical aspects of care are prioritized, performed, and that relevant information about the effectiveness of these functions is reported to the Quality, Service and Safety Committee.

(v) At all times during the Integration Period, the Chair of the Quality, Service and Safety Committee shall be a physician member of the Board of the Corporation.

(e) **Executive Compensation.** The Executive Compensation Committee shall be composed of members who are independent in accordance with Internal Revenue Service guidance for organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers. The Committee shall evaluate and approve compensation, and changes to compensation, for the Executive Chair/President. The Committee shall consider and approve the compensation for the Chief Executive Officer, any executive vice president or senior vice president based upon the recommendation of the Executive Chair/President. Evaluations by the Executive Chair/President or CEO of the performance of any executive vice president or senior vice president shall be made available if requested by the Executive Compensation Committee for its use in consideration of the recommended adjustment to compensation. In evaluating compensation, the committee shall satisfy the Rebuttable Presumption of Reasonableness standards as promulgated by the Internal Revenue Service as amended from time to time.

(f) **Community Benefit and Population Health.** The Community Benefit Committee's responsibilities shall include: (1) extending and strengthening the Corporation's community benefit programs and services, (2) review community benefit strategies and performance to assure adequate financial and human investments are maintained, (3) monitor the community benefit reporting to ensure integrity of the information, (4) ensure compliance with community benefit standards imposed by regulatory agencies, (5) ensure public recognition of community benefit activities and community value through periodic reports to the community, (6) review of population health initiatives, and (7) oversight of compliance by the Corporation with the terms of any Certificate of Public Advantage to which the Corporation is subject. The committee shall report its findings and recommendations to the Board.

(g) **Governance/Nominating Committee.**

(i) The Governance/Nominating Committee shall be responsible for ensuring there is an effective process for filling board and committee positions, and that timely recommendations are made for the Board of Directors to consider. This committee shall also consider, from time to time, issues of governance, including review of bylaws, rules, and regulations, and establishing governance goals. The Governance/Nominating Committee shall also consider and recommend education and other resources for enhancement of Board performance, and shall lead the annual Board self-evaluation. The Executive Chair/President shall be an ex-officio member of the Governance/Nominating committee. Upon the creation of vacancies on the Board or on committees of the Board, the Executive Chair/President shall collaborate with the members of the

Board of Directors to facilitate recommendations to the Governance/Nominating Committee for consideration. The Executive Chair/President shall not vote on matters relating to nominations, but may vote on governance matters.

(ii) At its discretion, the Governance/Nominating Committee shall evaluate the advisability of adding to the Board of Directors one additional voting director, who, among other qualifications as determined by the Governance/Nominating Committee, shall (i) be a nationally recognized, independent health care expert, (ii) not residing in the Northeast Tennessee or Southwest Virginia region, (iii) who provides incremental value to the Board of Directors through competencies or relationships not then available to the Board of Directors, and (iv) who has not been previously engaged by or with Wellmont Health System or Mountain States Health Alliance nor has been involved in a financial, business, investment or family relationship with the Executive Chairman/President or CEO of the health system (the "Additional Independent Director"). If the Governance/Nominating Committee determines that the Additional Independent Director is advisable, it shall undertake a search process to fill that position whose nomination the Governance/Nominating Committee is prepared to submit to the Board of Directors.

(h) **Workforce Committee**. The Workforce Committee shall provide recommendations to the Board of Directors on matters relating to the workforce of the Corporation, including, but not limited to, matters relating to: (1) implementation of workforce plans for recruitment and retention, (2) policies which support the workforce plan, (3) education and professional development of the clinical workforce, (4) competence of the workforce, (5) policies and practices related to a safe and productive workplace, (6) benefits, and (7) any opportunities related to the facilities of the Corporation becoming and remaining the health care workplace of choice.

Section 5. Clinical Council. A physician-led clinical council will be maintained, composed of independent, privately practicing physicians as well as physicians employed by the Corporation or its subsidiaries or affiliates. The Clinical Council will include representatives of management, but the majority will be composed by physicians. The Clinical Council will report to the Chief Medical Officer of the Corporation, or to the senior officer of the Corporation if there is no Chief Medical Officer. The Chair of the Clinical Counsel will be a physician member of the active medical staff(s) of one or more affiliated hospitals, will serve on the Quality, Service and Safety Committee of the Board, and will provide ongoing reports on the activities of the Clinical Council to the Board through the Quality, Service and Safety Committee of the Board. Among other duties assigned to it from time to time, the Clinical Council will endeavor to establish a common standard of care, credentialing standards, consistent multidisciplinary peer review where appropriate and quality performance standards. The Clinical Council will provide input on issues related to clinical integration, and shall support the goals established by the Board of Directors. The Clinical Council members serve at the pleasure of the Board of Directors and may be removed with or without cause.

ARTICLE VIII
MEMBER CORPORATION BOARDS

Section 1. Appointment. The Corporation is the sole member of Mountain States Health Alliance and Wellmont Health System (the "Subsidiary Corporations"). The Corporation's Board of Directors shall also serve as the Board of Directors of each of the Subsidiary Corporations pursuant to the Amended and Restated Bylaws of each Subsidiary Corporation.

Section 2. **Delegation of Authority.** Subject to limitations prescribed exclusively by the Board of Directors, the board of directors of each Subsidiary Corporation shall perform the following duties: (i) oversee the relationship of each Hospital owned by the Subsidiary Corporation with its physicians and other medical providers, including administration of the credentialing and disciplinary process applicable to such Hospital's medical staff, (ii) assure compliance by the Hospitals owned by the Subsidiary Corporation with the accreditation standards promulgated by the Joint Commission, and (iii) govern the business and affairs of the Subsidiary Corporation, subject to the limitations set forth in these bylaws and the Articles of Incorporation the Subsidiary Corporation. The board of directors of each Subsidiary Corporation shall provide reports to the Board of Directors regarding actions taken pursuant to the delegation of duties specified above in a manner prescribed by the Board of Directors. The board of directors of each Subsidiary Corporation is authorized to exercise the powers, authority and responsibilities set forth in this Section 2 pursuant to this delegation by the Board of Directors of the Corporation. Any powers not specifically delegated in this Section 2 are reserved to the Board of Directors of the Corporation.

ARTICLE IX
MISCELLANEOUS

Section 1. **Corporate Seal**. The Board of Directors may provide a seal for the Corporation in the form approved by the Board of Directors.

Section 2. **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of July of each year.

ARTICLE X
NOTICE

Whenever under the provisions of the Act, the Charter, or these Bylaws notice is required to be given to any director, officer, or committee member of the Corporation, it shall not be construed to require personal notice, but such notice, unless required to be in writing, may be given by telephone or electronic mail and, if given in writing, may be given either personally or by facsimile, or by depositing the same in a post office or letter box in a postpaid, sealed wrapper., in either case addressed to such director, officer, or committee member at his or her address as the same appears in the records of the Corporation; and the time when the same shall be so mailed or faxed, shall be deemed to be the time of the giving of such notice.

ARTICLE XI
INDEMNIFICATION

Section 1. **Indemnification of Officers and Directors**. The Corporation shall indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an officer or director (whether voting or non-voting) of the Corporation, including a director of a Hospital Board, against liabilities and expenses incurred in the proceeding to the fullest extent permitted by the Act. The Corporation shall make advances for expenses incurred or to be incurred in the proceeding as provided for in the Act.

Section 2. **Indemnification of Employees and Agents**. The Corporation may indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an employee or agent of the Corporation against liabilities and expenses incurred in the proceeding

to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act. The Corporation may make advances for expenses incurred or to be incurred in the proceeding to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act.

Section 3. **Insurance**. The Corporation shall have the power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the Corporation (including a director of a Hospital Board), or is or was serving at the request of the Corporation as a director, officer, employee, or agent of another Corporation, partnership, joint venture, trust, or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have the power or would be required to indemnify him or her against such liability under the provisions of this Article.

Section 4. **Nonexclusivity**. The rights of indemnification and advancement of expenses granted pursuant to this Article shall not be deemed exclusive of any other rights to which an officer, director, employee, or agent seeking indemnification or advancement of expenses may be entitled, pursuant to the Act, Tennessee statutory or case law, the Corporation's Charter, these Bylaws, a resolution of the Board of Directors, or an agreement or arrangement providing for indemnification; provided, however, that no indemnification may be made to or on behalf of any officer, director, employee, or agent, if a judgment or other final adjudication establishes that such indemnification is prohibited by Section 48-58-502 of the Act or any successor statutory provision.

Section 5. **Statutory Immunities**. Nothing contained in this Article X shall be construed to prejudice or otherwise diminish the limitations, immunities and other protections available to the directors and officers of the Corporation (including a director of a Hospital Board) pursuant to Section 48-58-601 of the Act or any successor statutory provision.

ARTICLE XII
CONFLICTS OF INTEREST

The Board of Directors shall adopt and maintain a Conflict of Interest Policy applicable to all members of the Board, Board Committees, Officers of the Corporation, and key management personnel. The policy shall require the annual completion and submission of an acknowledgement and disclosure statement, as well as a confidentiality agreement applicable to all business of the Board of Directors.

ARTICLE XIII
VOLUNTEER AND AUXILIARY ORGANIZATIONS

Volunteer and Auxiliary organizations may, with the approval of the Board of Directors of the Corporation, perform nonprofessional services within the affiliated entities which further the purposes and interests of the Corporation. Such volunteer organizations, in discharging their functions, shall cooperate closely with management of the affiliated entity and the Board of Directors or its designee. Such cooperation may include a requirement for production of reports or information relevant to the services and benefit being provided. The activities of the volunteer or auxiliary organizations shall, if the Corporation's Board of Directors deems proper and necessary, be carried out under bylaws adopted by such organizations, and such bylaws and any amendments thereto shall be subject to revision by, and approval of, the Board of Directors or its designee. The

Board of Directors may require Board of Directors approval of appointments to the Board of any Volunteer or Auxiliary Organization.

ARTICLE XIV
AMENDMENTS

Section 1. **Periodic Review of Bylaws.** The Board of Directors shall cause these Bylaws to be reviewed annually to determine whether any amendments or revisions are necessary or desirable from a legal, regulatory or operational standpoint when considered in light of best industry or nonprofit organization practices. The Governance/Nominating Committee shall conduct such review and make recommendations to the Board of Directors..

Section 2. **Amendments**. Subject to Article III, Section 5 above, these Bylaws may be altered, amended, or repealed, and new Bylaws may be adopted, by the Board of Directors at any meeting, whether annual, regular, or special, by a majority vote of the voting directors serving on the Board of Directors. A full statement of the proposed amendment, or amendments, to these Bylaws shall be set forth in the notice of each such meeting.

ARTICLE XV
DEFINITIONS

For purposes of these Bylaws, the following terms shall have the following meanings:

"Category J Directors" means those directors initially appointed jointly by Mountain States Health Alliance and Wellmont Health System pursuant to the Master Affiliation Agreement and Plan of Integration dated as of February 15, 2016, by and between Wellmont Health System and Mountain States Health Alliance (the "Affiliation Agreement"), and their successors as appointed in accordance with the Bylaws of the Corporation.

"Category M Directors" means those directors initially appointed by Mountain States Health Alliance pursuant to the Affiliation Agreement, and their successors as appointed in accordance with the Bylaws of the Corporation.

"Category W Directors" means those directors initially appointed by Wellmont Health System pursuant to the Affiliation Agreement, and their successors as appointed in accordance with the Bylaws of the Corporation.

"***Closing Date"*** means of the closing date pursuant to the Affiliation Agreement.

"Integration Period" means the period beginning on the Closing Date and ending on the second anniversary of the Closing Date.

Exhibit A

Description of the Vice Chair/Lead Independent Director Position

Charter of the Vice Chair/Lead Independent Director

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

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

Presides at Executive Sessions

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

Calls Meetings of Independent Directors

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

Conducts Evaluation of Executive Chair/President

- Ensures the Executive Committee, or another committee as determined by the Board, conducts an annual review of the performance of the Executive Chair/President, with such review being approved by the non-management members of the Board of Directors.
- Ensures annual compensation review of the Executive Chair/President by the Executive Compensation Committee upon the completion of the annual performance review of the Executive Chair/President.

Functions as Liaison with the Executive Chair/President

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

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

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

Authorizes Retention of Outside Advisors and Consultants

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

Exhibit 10

Benefits and Potential Disadvantages that may Result from the Cooperative Agreement

Exhibit 10

Benefits and Potential Disadvantages

The proposed transaction involves several key features that differentiate the assessment of its overall advantages and disadvantages from a more traditional hospital merger. These include:

- The specific geography, which is largely rural, and the population served, including their current and anticipated health needs. Population growth in many of the rural communities has been negative,[1] and projections demonstrate flat-to-no population growth against a backdrop of significant downward pressure on inpatient utilization. In many rural hospitals, where the census is below 30, this is a substantial threat to viability under the status quo environment;
- The implications of those health needs on the economic vitality and sustainability of the workforce and competitiveness of the region for Tennessee and more generally; and the overall economic health and wellbeing of the communities in eastern Tennessee;
- The resources and assets needed to efficiently and effectively meet health needs of this diverse population, including the uninsured, Medicaid, Medicare, and commercial populations, now and in the future. Assets and resources include physicians, clinics, outpatient facilities, and inpatient hospital facilities, and the alignment and location of the right assets and resources in the best locations to serve the population;
- The current configuration of the healthcare delivery systems in the area as compared to the efficient and effective configuration of delivery systems – by type of facility and also integration across facilities;
- The supporting infrastructure and investments to manage and improve population health, clinical services, care delivery, and services to improve patient experience and care, outcomes, and address needed priorities at lower and sustainable costs; examples include physician leadership and best practices, clinical coordination and integration, and IT/EHR capabilities across the area and care locations;
- Alignment of the healthcare delivery systems with new payment models and metrics and with payers to establish contracts and methods that seek improved outcomes, access, and reduced costs – increasingly, payers seek contracts with better measures of reduced total medical costs and improved outcomes, not just lower unit prices;
- The likely alternatives to the proposed transaction, including status quo and alternatives;
- The context in which the transaction occurs – namely, a COPA model with specific commitments, conditions, and requirements of the Parties with active supervision by the State.

How do these features differentiate the merger review of the advantages and disadvantages of the proposed transaction from a more traditional merger?

A traditional merger review tends to focus on the predicted and likely effect of the proposed transaction on prices facing commercial health plans and whether these effects are likely to be anticompetitive. The expected benefits of the transaction are often examined with regard to expected merger-specific cost reductions (efficiencies) and gains from realignment of inpatient hospital resources/services, including some consideration of expected quality effects. Costs and benefits have traditionally been evaluated with regard to the implications of predicted prices or

[1] *See* United States Census Bureau Statistics for County Population, percent change - April 1, 2010 to July 1, 2015, available at: http://www.census.gov/quickfacts/table/PST045215/00.

quality effects on patient populations, payers, and/or employers based on future medical costs of inpatient services and their impact on premiums, co-pays and deductibles. The analyses are typically predicated on models that assume that the current marketplace *is at a competitive equilibrium* and that, but-for the merger, competition between two or more independent health systems for commercial contracts would achieve lower prices and higher quality. Generally, these analyses assume away any need for transformational or substantial change in the organization of care delivery by providers and that the assessment of competitive effects on commercial payers can largely be conducted without reference to Medicaid, Medicare, or uninsured populations.

The COPA context is fundamentally different, and the features of this transaction and of the geographic region set out above yield a substantially different advantages/disadvantages calculation for the proposed transaction. Briefly, some of those differences include:

- *Transactions subject to COPA, including this transaction, are a unique set*. They fundamentally involve transactions with major systemic risks to the healthcare delivery system and the merging hospitals, the communities, and the population if they *do not* proceed. These systemic risks and the associated weight of public advantages created are balanced with some antitrust risks under a permitted merger and further mitigated through active supervision by the state. COPA transactions are very likely to include those where the "but-for" world – the world without the proposed transaction or with alternative purchasers -- reduces the potential antitrust risks yet yields very limited, if any, gains or may even yield a substantial reduction in benefits relative to the status quo. For example, in this case, the proposed transaction occurs in an area with multiple challenges and where sustainable competition between two large independent systems is not the most efficient or highest value outcome.
- *The implication is that COPA analysis weighs heavily the collective advantages of the transaction, the collective disadvantages, the practicality of the alternatives to the transaction, and the particular means to assure that the known advantages are achieved and known disadvantages are mitigated or limited substantially by the benefits*.
- *The transaction addresses all populations across all communities*. The benefits to be achieved in terms of enhanced access, reduced costs, improved patient and population experience, quality and outcomes adhere to far more than commercially insured populations. The COPA context values very highly the gains to all populations, patients and residents, from the transaction and not just commercially insured patients – measures of the advantages of the transaction include broader populations, longer term benefits, and improved care and experience across the area, rather than narrower evaluation of specific commercial populations with shorter term quality or price effects.
- *The COPA context provides for the translation of cost-savings and efficiencies into specific commitments, resources and investments to be made by the Parties.* This provides the incentive to achieve the savings, not otherwise likely to occur, and to commit specific resources in specific ways to benefit the overall community and population health. This provides the opportunity for the specific commitments and investments to be directly aligned with community priorities and needs (e.g., investments in new clinics, in new services, in specific population health initiatives) with metrics and methods for reporting and tracking. Investments may also include expedited and area-wide or system-wide clinical initiatives, infrastructure and alignment of care that are part of the commitments made to integrate and align the two competing systems
- *The COPA context provides for mechanisms to keep pricing within a competitive range, using market-based methods that rely on known contracting mechanisms; and contracting terms and*

conditions that might be derived from competition. The COPA essentially provides an enforceable mechanism to ensure that pricing under negotiated agreements will change at a rate not to exceed the upper limits of what might occur in the absence of the transaction.

This section addresses how the proposed transaction between Wellmont and Mountain States – when evaluated with this broader and more appropriate COPA-specific advantage/disadvantage framework – results in material and measurable benefits that far outweigh potential disadvantages.

Benefits of the Proposed Merger

In evaluating the potential benefits of a cooperative agreement, the department shall consider whether the following benefits may result from the cooperative agreement:

(A) Enhancement of the quality of hospital and hospital-related care provided to Tennessee citizens;

Situation: Steadily increasing financial pressures on Wellmont and Mountain States require ever-increasing efficiency in order to maintain the excellent level of care historically provided by both systems. Under the proposed merger, the New Health System will be significantly better equipped to deliver enhanced services and improve the overall quality of health care through a fully integrated system of care that utilizes a common clinical IT platform, a regional health information exchange, a system-wide clinical council, and enhanced quality reporting.

Background: As noted in the Application, the two health systems currently have expensive, duplicative healthcare resources that are allocated inefficiently. A merger would enable elimination of unnecessary duplication to capture large cost savings and realign resources to improve access and quality. The evidence shows there are two additional pressures which drive the necessity for consolidation and reduction in avoidable and unnecessary duplicative cost in order to sustain quality and access. Population stagnation in the region combined with downward pressure on inpatient use rates and downward pressure on government and commercial growth in reimbursement rates create limiting factors even as costs for labor and supplies continue to grow.

In fact, there is a triad of pressures including population trends, use rates and reimbursement. The key areas served by the combined system have seen, and will see, little to no population growth. For instance, Sullivan County and Washington County increased by less than 1 percent, Carter decreased by 1.6 percent, Johnson decreased by 2.3 percent, Unicoi decreased by 2.5 percent, and Hancock decreased by 3.6 percent.[2] The Virginia counties have seen even worse declines, with Smyth decreasing by 2.3 percent, Russell decreasing by 3.5 percent, and Wise and Scott counties decreasing by 4.2 and 4.5 percent respectively.[3]

Combining the stagnant population with expected decreasing hospital inpatient use rates will have a serious adverse effect on the health systems. If the Parties remain separate, this will create a shift in the cost structure to a higher percentage of costs being deployed for fixed corporate, rather than clinical, purposes, since each system would be required to sustain duplicative corporate functions and the fixed cost associated with these functions. Consolidation

[2] *Id.*
[3] *Id.*

of the two systems enables a substantial reduction in fixed overhead cost. For instance, the current inpatient use rates in the region, which are 126 per 1,000 population, are higher than the current national range of 106 per 1,000. Given the increasing strategy by payers of shifting to risk-based contracting for physicians, the stated desire of payers to reduce inpatient utilization and the shift to increased use of outpatient services, it is expected that the region's inpatient use rates will decline. Assuming a 2015 population for the 21-county Geographic Service Area of 960,019,[4] if the current use rates decline to the top of the national range, this would represent a decline of somewhere between 15,000 and 16,000 discharges.[5] If use rates decline to the lower end of the range, the decline would be as many as 34,000 discharges.[6]

Declines of this magnitude can be offset by population growth, which has occurred in certain areas in the country. In those instances, declining use rates may not mean significant volume declines in hospitals. But in a rural area, where many hospitals are operating at lower volume, it is difficult for hospitals to sustain their efforts with such significant declines in volume. Low population growth and declining use rates are intrinsic to the outlook for this region and there will be a high correlation between declining use rates and actual volume decline in the region's hospitals collectively. Already, many of these hospitals have negative operating margins. Without the COPA, it is likely some of these hospitals will fail. Declining volume in the larger hospitals, combined with the duplicative costs each system will continue to bear, will decrease the ability of those hospitals to financially support the smaller hospitals. It is important to note that if some of these hospitals were to fail, it could potentially lead to reduced access for consumers, and even reduced choice if a hospital were to close. Through the Parties' commitment to utilize synergies to sustain these access points, the COPA provides a rational approach to managing service provision and capacity and the alignment of the combined system based on the needs of the communities.

In addition to these challenges, fixed rate increases in Medicare, commercial plans and Medicare Advantage plans are simply no longer reliable. For the coming federal fiscal year, the region faces yet another decrease in the Area Wage Index. This decrease is despite the fact that the region has the second lowest wage index in the United States. This represents a decrease in federal reimbursement, which cascades to most of the commercial payers.

What is potentially left are two independent systems with significant duplication of fixed administrative cost structures, lower inpatient volumes, and significant clinical duplication dedicated to supporting capacity that may no longer be needed. All of this is combined with a revenue stream which does not support growth in capital investment or even sustainability of the current cost structures.

The Parties believe quality will suffer in this status quo environment as the systems lose their capacity to capitalize or face substantially higher costs for doing so. Remaining separate, the two systems will not have the ability to standardize, eliminate variation and take advantage of scale. These limitations on capital will lead to decreased efforts to diversify the specialties which may

[4] The population estimate is for the 21-county service area. Sg2 Market Demographics: Population Trends (2016).
[5] This estimate assumes a decrease in inpatient utilization in the 21-county service area from the current rate of 126/1,000 to 110/1,000.
[6] This estimate assumes a decrease in inpatient utilization in the 21-county service area from the current rate of 126/1,000 to 90/1,000.

be needed, but do not generate significant revenue, such as pediatrics, and other medical specialties which, ironically, help reduce the demand for inpatient utilization when they are available in the market.

Numerous studies have shown that critical mass in volume leads to better outcomes.[7] Reduced fragmentation, clinical scale and elimination of variation all become important factors in reducing cost and improving quality. A combined system that is able to utilize the tools and protocols described in the Application is better positioned to use this scale to achieve these desired outcomes than two separate systems would be able to do in a declining admission, population stagnant environment. As outlined elsewhere in this document, another option is for each system to join larger out-of-market systems. Such a system does not have the ability to realign in-area capacity and resources to the benefit of the local economies and community and to improve efficiency and sustainability of care to serve substantial local population health needs of Medicare, Medicaid, uninsured, and commercial patients in largely rural communities.

Assessment: In addition to maintaining the scale needed as a counter to population stagnation and decreasing usage rates, to achieve enhanced quality of hospital and hospital-related services, the New Health System should adopt, implement and fund technology, policies, and programs that are not possible for the two separate and competing health systems to accomplish. This should include the following essential components:

- Common Clinical IT Platform: A Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care and will also facilitate the development and increased adoption of best practices and evidence-based medicine implemented by the New Health System. Availability of immediate system-wide alerts and "hard-coding" best practice protocols for clinical pathways has been demonstrated to enhance overall quality by reducing the risk of clinical variation and lowering the cost of care by decreasing duplication of health care services. The cost of implementation of a Common Clinical IT Platform is built into the capital model for the New Health System. Standardized order sets, collection of data and standardization of data sharing with physicians are all benefits that would be immediately achieved with the Common Clinical IT Platform once fully implemented. While some might argue that the two systems, remaining independent, could collaborate on these issues, the Parties strongly disagree. Even if Mountain States were to acquire the EPIC system independently, the IT systems would not be identical, and patients would continue to have two records – one for Wellmont and one for Mountain States. Protocols between the two systems would not be identical and the accountability structure (i.e., the Boards of Directors) would remain separate. There would be little incentive for physicians, who remain competitive, to share information. The collection of data for academic studies and research purposes would be

[7] *See High-volume trauma centers have better outcomes treating traumatic brain injury*, Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, Journal of Trauma and 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.

further complicated by the need to navigate two separate systems with separate protocols and data sharing capabilities.

- Region-Wide Health Information Exchange - A region-wide health information exchange that includes the New Health System, independent providers, medical groups and facilities in an effective collaborative model will encourage and support patient and provider connectivity to the New Health System's integrated information system. Though a health information exchange does not have the ability to achieve the level of clinical integration possible through a common electronic medical record system, it is an important component for the management of shared patients between physicians, hospitals, and outpatient settings especially for the avoidance of unnecessary duplication of testing and care coordination to close care gaps. Among other benefits, the seamless sharing of this information will reduce unnecessary cost, mitigate risk to patients and enable improved productivity among providers. After the transaction, the New Health System will commit financial resources to the utilization of an effective health information exchange. These incremental resources will contribute to the sustainability of an effective health information exchange model.

- System-Wide Clinical Council - System-level clinical councils have the ability to drive clinical effectiveness, manage change, and evaluate initiatives through physician leadership and expertise. Best practice and local feedback demonstrates that the New Health System should establish a Clinical Council composed of independent physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates—including those physicians that practice in hospitals as well as those that practice primarily in outpatient environments. Further, the Clinical Council should be supported by other clinicians, subject matter experts, and senior management. This group should report frequently to the board of the New Health System through the Chief Medical Officer to facilitate the board's responsibility for quality improvement. Nationally, clinical councils are effective in establishing common standards of care, credentialing standards, consistent multidisciplinary peer review where appropriate and quality performance standards and best practices. For the New Health System, the Clinical Council should also provide input on issues related to clinical integration and support the goals established by the Board of Directors of the New Health System.

- Quality Reporting - Effective quality reporting is an essential component of any integrated clinical system with accountability to the community. This calls for complete transparency on quality measures with respect to the performance of the New Health System on a common and comprehensive set of measures readily available for consumers. This will impact choice and further incentivize the provision of high-quality care. Increased transparency will provide consumers with information to make better health care decisions. For meaningful comparison, this reporting system should include CMS core measures including patient experience scores for each facility within thirty days of reporting the data to CMS. The reporting system should also provide benchmarking data against the most recently available CMS data so the public can evaluate and monitor how the New Health System facilities compare against hospitals across the state and nation in a manner that is more "real time" than currently available and as far in advance of the federal agency reporting as possible.

The Parties believe quality will not diminish under the COPA and point to the experience of Mission Health in Asheville as support for this position. Mission Health was granted a COPA in

1995 and has been recognized nationally for its low cost and high quality health care. For seven years in a row, Mission has been named a Top 100 hospital, and for three years in a row, has been named a top 15 health system in the nation. Under the COPA, quality at Mission has been sustained and costs are lower relative to their peers. According to data provided by the State of North Carolina, the costs for health care services at Mission have been sustained at a lower level than its peers in the state. In fact, Mission Health has been recognized as one of the best examples in the country of health systems that have successfully achieved higher quality while maintaining low costs.[8]

Competition was reduced in Asheville by the merger, but, because of the implementation of the COPA and state supervision over Mission's commitments, health care costs have remained low and health care quality has improved. The Parties note that the U.S. Department of Justice and the North Carolina Attorney General's Office recently took legal action against another health system in North Carolina (Carolinas HealthCare). The legal action alleges anticompetitive behavior by Carolinas Healthcare which could increase pricing and reduce consumer choice.[9] The claims made against Carolinas Healthcare have never been made by a federal or state agency against Mission Health. The Parties note that the anticompetitive behaviors that Carolinas Healthcare has allegedly engaged in are explicitly prohibited by the COPA regulating Mission Health, and Mission has not engaged in such behaviors. The Parties have proposed commitments in their Application that are similar to the Mission Health commitments. These are intended to prohibit the anticompetitive behaviors that triggered the federal and state action against Carolinas Healthcare. The Parties believe such commitments, when properly supervised, reduce the likelihood of the behavior alleged by the Department of Justice in the Carolinas Healthcare case, and protect high quality and low cost.

Recommendation: To ensure that enhanced quality of hospital and hospital-related care is provided to Tennessee citizens under the merger, Mountain States and Wellmont have proposed the following commitments to be actively supervised by the state:

- The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.
- The New Health System will participate meaningfully in the exchange of health information open to community providers.
- The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.
- The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully in the Application.

[8] *See* "Mission One of Ten Hospitals Named for 'Doing It Right,'" *Mission Health Scope*, August 7, 2009, available at: http://www.mission-health.org/sites/default/files/document-library/1292_0.pdf (accessed July 12, 2016).
[9] See " State and feds say Carolinas HealthCare drove up costs by curbing competition," *The Charlotte Observer*, June 9, 2016, available at: http://www.charlotteobserver.com/news/local/article82726402.html (accessed July 12, 2016).

- The New Health System will collaborate with independent physician groups to develop a local, region-wide clinical services network to share data, best practices, and efforts to improve outcomes for patients and the overall health of the region.

(B) Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities;

Situation: The Parties believe that it will be increasingly difficult to continue financially supporting rural facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based and clinical services is a driving impetus for the Cooperative Agreement. The COPA is the only means to achieve the efficiencies necessary to sustain rural facility operations and preserve and enhance access to quality care in geographical proximity to the communities traditionally served by those facilities.

Background: Health care services offered by rural hospitals in the United States are increasingly at risk of closure. According to the University of North Carolina Sheps Center, seventy-six rural hospitals have closed since 2010, including eight in Tennessee and one in Virginia.[10]

Providers throughout the nation, including Wellmont and Mountain States, are faced with reduced payment for services, services moving from the inpatient to the outpatient setting, and higher patient out-of-pocket costs due to increased copayments and deductibles which have led to more hospital bad debt. The challenges are intensified in the Parties' service area of Northeast Tennessee and Southwest Virginia, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant health care challenges.[11]

As presented in Tables 5.2 and 5.3 of the COPA Application, many of the Parties' rural hospitals have an average daily census of twenty patients or less. Currently, most rural hospitals operated by Wellmont and Mountain States operate with negative or very low operating margins, representing challenges to the capitalization and, ultimately, the survival of these hospitals.

Last year alone, Mountain States and Wellmont collectively invested more than $19.5 million to ensure that inpatient services would remain available at the following rural hospitals: Smyth County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Johnson County Community Hospital, Dickenson Community Hospital, Hawkins County Memorial Hospital, Hancock County Hospital, Lonesome Pine Hospital, and Mountain View Regional Medical Center.

In the current resource-constrained, status-quo environment, these hospitals face an uncertain future with respect to their viability, and, in fact, may be in peril. A recent report estimates 673

[10] *See 76 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, *available at*: https://www.shepscenter.unc.edu/programs-projects/ruralhealth/rural-hospital-closures/ (accessed July 13, 2016). Ten rural hospitals have closed since the COPA Application was filed in February, 2016, including two rural hospitals in Tennessee.

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

rural hospitals are vulnerable or at risk for closure nationwide.[12] The existing threat to these hospitals is substantial, which affects not only patients' access to local care in geographic proximity to their homes, but also affects the economic vitality of these communities.

These rural facilities are supported by three regional tertiary hospitals located along major highways that connect the rural markets to the Tri-Cities. These hospitals—Johnson City Medical Center, Bristol Regional Medical Center, and Holston Valley Medical Center—serve distinct patient bases in a hub and spoke model to distinct rural geographies. Each of these hospitals provides an array of high-level services that are essential to the greater Tri-Cities region of Northeast Tennessee and Southwest Virginia communities they serve. They are also major regional teaching facilities with a variety of academic partners in Virginia and Tennessee. The financial support for these rural hospitals is generated largely by the tertiary facilities. As stated earlier in this document, population stagnation and decreased inpatient use rates will increasingly challenge these hospitals' ability to continue supporting rural facilities as redundant, duplicative costs remain.

Assessment: The COPA is a mechanism for ensuring that the efficiencies from the merger will be used to ensure sustained access to care for these communities. *Without the Cooperative Agreement and the commitments in the COPA, there is no comparable assurance from the two health systems*. The Parties believe the evidence supports the assertion that these hospitals are threatened as population stagnates and financial support from the tertiary facilities become increasingly difficult to sustain. The commitment to keep these facilities open and to preserve access to existing healthcare services in these rural markets creates a public advantage that does not exist today and that cannot exist without the merger. This commitment also mitigates the risk that healthcare services will not be maintained in reasonable geographical proximity to the communities served by these hospitals. The timeframe associated with this commitment should acknowledge that healthcare services are constantly evolving locally and nationally and some repurposing of existing facilities may be needed to meet specific community needs, some of which are not necessarily being met today. The commitment should also address retention of high-level tertiary services in a teaching hospital environment at the region's existing tertiary hospitals.

Recommendation: In order to preserve hospital facilities in geographical proximity to the communities traditionally served by those facilities, Mountain States and Wellmont have proposed the following commitments to be actively supervised by the state:

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

[12] *See* 2016 Rural Relevance: Vulnerability to Value. A Hospital Strength INDEX Study. Ivantage. Accessed on June 13 at https://tinyurl.com/j3gaatc.

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

(C) Gains in the cost-efficiency of services provided by the hospitals involved;

Situation: The existing competitive dynamic between Wellmont and Mountain States has led to expensive duplication of equipment and facilities. The merger would allow the New Health System to achieve greater cost efficiencies through various organizational and administrative efficiencies, including non-labor efficiencies, labor efficiencies, clinical efficiencies, and the opportunity to consolidate technology resources on a Common Clinical IT Platform.

Background: Federal and state regulatory agencies impose significant cost constraints on all hospital providers. Medicare and Medicaid payment rates are non-negotiable and are often applied as benchmarks by other payers. Medicare costs are regulated through the Medicare Wage Index. In Northeast Tennessee and Southwest Virginia, payment rates remain lower because the local Medicare Wage Index is one of the lowest in the nation. With a payer mix for the regional health systems that is approximately 70% Medicare, Medicaid, and Medicare managed care, this wage index serves as a fundamental regulator of health care costs.[13]

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

Through the Cooperative Agreement and the commitments in the COPA, the two health systems will be able to avoid unnecessary duplication of services. By integrating their efforts in key service areas, the Parties will avoid duplicative costs and will be able to operate these facilities and services more efficiently, with better quality and with enhanced patient outcomes. One example of duplicative services the New Health System can potentially consolidate is the area's two Level I Trauma Centers, which are expensive to maintain and redundant in a region with low population density. No other region in Tennessee operates two Level I Trauma Centers.

Consolidation of these programs into a single facility is projected to result in cost savings. Significantly, studies have shown that higher-volume trauma centers result in better patient outcomes.[14] Thus, a consolidation is not only likely to result in lower cost, but it is also likely to result in improved outcomes. Other cost-saving and efficiency opportunities include consolidation of specialty pediatric services, repurposing acute care beds and consolidation of certain co-located facilities. This repurposing will lead to higher volumes in the acute care and other consolidated facilities, and thus, better efficiency. The quality of care is also expected to improve since studies indicate quality is generally better in higher volume environments.[15]

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

[14] *See High-volume trauma centers have better outcomes treating traumatic brain injury*, Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, Journal of Trauma and 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.

[15] *Id*.

Access is also expected to improve because the repurposed facilities may be able to add services that could not be previously supported in an environment of duplication and low capacity.

Recommendation: To ensure the merger results in gains in the cost-efficiency of services provided by the hospitals involved, Wellmont and Mountain States have committed to achieve at least $95 million in annual efficiencies by the end of the fifth year of operation. The potential savings are limited to the estimated dollar savings from the realignment of resources and certain clinical efficiencies, but do not include the potentially significant benefits that the Parties expect to achieve through improved access, quality, and care in the best locations that will directly benefit these communities.

(D) Improvements in the utilization of hospital resources and equipment;

Situation: Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thus contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and the realignment of services to reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers.

Background: Collectively, Wellmont and Mountain States serve a region with one of the highest inpatient use rates. Currently, for every 1,000 people in the region, 126 are admitted to the hospital annually, compared to a national average of 106 admissions per 1,000. The current lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region which contributes to the overutilization of costly inpatient services. Unnecessary duplication of high cost services contributes to this trend. A major factor in the accumulation of nearly $1.5 billion of debt, and the redundant costs borne by the market, has been the duplication of services and programming by Wellmont and Mountain States as separate systems. These costs must be covered through clinical revenues and that contributes to higher costs.

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

Assessment: Combining the region’s two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost and enable the New Health System to reduce overutilization of inpatient services and stem the pace of healthcare cost growth for patients, employers and insurers. These efforts will enable the creation of a regionally integrated health system, with a comprehensive regional health information exchange, that will help reduce unnecessary utilization. This integrated delivery model will not

be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources.

Because of their regional proximity and high levels of duplication, the Cooperative Agreement will enable the two health systems to avoid unnecessary duplication and over-utilization thereby containing costs, achieving greater efficiency and improving utilization of high-cost hospital services. By integrating their efforts in key service areas, the Parties will avoid duplicative costs and will be able to operate these facilities and services more efficiently, with better quality and with enhanced patient outcomes.

One example of how the integrated delivery system could reduce the utilization of hospital resources is behavioral health. According to the American Hospital Association, one in four Americans experiences a behavioral health issue or substance abuse disorder each year, with the majority of those also experiencing physical health conditions or chronic diseases that complicate care needs. Thus, these patients typically have higher levels of health care utilization. It has been estimated that medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder conditions can be 2-3 times as high as for those who do not have a mental health/substance abuse disorder. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thereby contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to support the development of effective behavioral health and substance abuse that reduces unnecessary hospital utilization.

These efforts could not be undertaken in the absence of the merger due to a variety of factors, including the need to share proprietary information, the fact that reduction in duplication of resources would absolutely not occur without the merger and the significant commitment of resources to be made by the Parties. Specifically, the Parties have committed to investing millions of dollars in new behavioral health community-based services, residential addiction recovery services, and a Common Clinical IT Platform that are needed to create an integrated system and would not be possible without the merger. Moreover, commitments relating to pricing, consolidation of services, standardization of practices, and procedures, would raise significant antitrust concerns if undertaken together by two independent hospital systems.

In order to most efficiently utilize hospital resources, important relationships must be developed across a continuum of community-based resources, primary care, intensive outpatient care, and inpatient care to appropriately address the utilization of hospital resources. In fact, effective systems of care and provider resources in the outpatient environment and the community go a long way in reducing the need for acute hospitalization or emergency department use. Though the New Health System will work to ensure appropriate inpatient resources exist, the development of outpatient systems of care, coordinated systems of care in the community, sufficient provider and specialized counseling resources, and residential recovery services will help manage the utilization of hospital resources.

Recommendation: To ensure the merger results in improvement in the utilization of hospital resources and equipment, the New Health System has proposed certain commitments which can only be funded through the cost-containment, cost-efficiency, improved utilization, and avoidance of unnecessary duplication derived from the merger. These commitments include the

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

The New Health System has also proposed creation of a local clinical network which would partner the health system with the physician community in sharing data, best practices, standardization of care models and reduction of unnecessary utilization.

(E) Avoidance of duplication of hospital resources;

Situation: A major factor in the accumulation of nearly $1.5 billion of debt, and the redundant costs borne by the market, has been the duplication of services and programming by Wellmont and Mountain States as separate health care systems. The significant ongoing duplication of health care services and costs in the region cannot be avoided without a consolidation. Funding the population health, access to care, enhanced health services, and other commitments described in the Application would be impossible without the efficiencies and savings created by the merger. By aligning Wellmont's and Mountain States' efforts in key service areas, the New Health System will drive cost-savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services.

Background: Wellmont and Mountain States have competed with each other in certain areas and with other health care providers since the formation of the two systems in the late 1990s. A result has been the unnecessary duplication of hospital resources that has not added value. By eliminating the duplication of hospital resources and investing in what evidence has shown will help make this region healthier, the Parties believe the New Health System will be able to control costs and make healthcare more affordable.

Assessment: Combining the region’s two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services moving forward. These efforts will provide savings that may be invested in higher-value activities in the region to help expand currently absent but necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. These new levels of development and job creation will not be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources.

The Applicants commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to identify the unnecessary duplication of hospital

resources and perform an economies and efficiencies analysis regarding the proposed savings and efficiencies that would be gained by the merger. As detailed on pages 82-84 of the Application, the economies analysis was divided into three major segments. Segment One was the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two was the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three was the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies").

The Parties have identified potential savings from the merger in the following areas that would not be possible but for the merger:

- Non-Labor Efficiencies
    - How the Merger Would Help: Cost-savings can be achieved through operational efficiencies. Examples include combined purchasing and use of a non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals.
    - Estimated Savings from the Avoidance of Duplication: The Parties have identified potential savings from the merger in non-labor expenses totaling approximately $70 million annually.
- Labor Efficiencies
    - How the Merger Would Help: The New Health System will reduce workforce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system.
    - Estimated Savings from the Avoidance of Duplication: The Parties have identified potential savings from the merger in labor expenses totaling approximately $25 million annually.
- Clinical Efficiencies
    - How the Merger Would Help: The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most effective levels of services at the right locations.
    - Estimated Savings from the Avoidance of Duplication: The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually.

Further, the extensive commitments described in the Application to improve access to health care and quality of health care could not be achieved without the combination and would not be effectively enforced absent an active state supervision program mandated by Virginia and Tennessee law.

Recommendation: To ensure the merger results in the avoidance of duplication of hospital resources, the New Health System has proposed certain commitments that would eliminate the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services. Specifically, Wellmont and Mountain States have committed to achieve at least $95 million in annual efficiencies by the end of the fifth year of operation. The potential savings are limited to

the estimated dollar savings from the realignment of resources and certain clinical efficiencies, but do not include the potentially significant benefits that the Parties expect to achieve through improved access, quality, and care in the best locations that will directly benefit these communities. By eliminating duplications, and the costs associated with those duplications, the New Health System will be able to re-direct those resources to maintaining and improving quality rather than duplicating services that result in excess capacity or underutilization. These efforts will provide resources that can be invested in more value-based spending in the region – spending that helps expand (and where absent, implement) necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community improves the health of this region's residents and the economy of its communities.

(F) Demonstration of population health improvement of the region served according to criteria set forth in the agreement and approved by the department;

RESPONSE: The population served by Mountain States and Wellmont has long had more significant health challenges than the population in the United States generally. The area served by the Parties has significantly higher rates of many chronic conditions such as obesity, diabetes, heart disease, and cancer.[16] Behavioral issues prevalent in the community, such as drug use, smoking, and poor nutrition, have made these conditions particularly difficult for health care providers to address in a meaningful way.

The New Health System commits to implementing programs and strategies to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and neonatal abstinence syndrome in the Geographic Service Area, as outlined in the template Community Health Improvement Plan, attached as Exhibit 21 to these Responses. Suggested short-term and intermediate-term outcome metrics are included in the template Community Health Improvement Plan. Because of limitations and lags in current federal and state population health data sources, especially at the county level, the Parties expect that final metrics and targets will be agreed upon with the Tennessee Department of Health. In order to make data actionable, new or augmented data collection efforts may be necessary. The "Year-by-Year Summary" that provides an estimate of the year-by-year timing of these reinvestments and cost savings is attached as Exhibit 22. All of these efforts recognize that ultimately, individual and community health and well-being are not primarily driven by health care services, but instead by income, education, family and community support, personal choices, genetics and the environment.

The New Health System expects to work collaboratively with the State to determine which specific interventions will be implemented where. While many evidence based programs exist to reduce tobacco use, obesity, drug poisoning, etc., it may not be possible to implement these locally without modification due to workforce, transportation or other infrastructure constraints.

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

Combining two strong health systems aligned with other providers along the care continuum as well as stakeholders in the community creates a unique opportunity to direct resources in a coordinated way and tackle these longstanding, expensive problems that reduce quality of life for so many of the state's most vulnerable citizens and communities.

(G) The extent to which medically underserved populations have access to and are projected to utilize the proposed services; and

Situation: Some residents in Northeast Tennessee and Southwest Virginia have acceptable access to many services, but other areas are substantially underdeveloped or lacking services altogether. Wellmont and Mountain States anticipate significantly improved access to health care services under the Cooperative Agreement and the commitments set forth in the COPA. The Cooperative Agreement will enable the hospitals to improve access to medically underserved populations through charitable care programs as well as continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The COPA will ensure that the New Health System is held accountable for the commitments the Parties have made to the state.

A recent *60 Minutes* story highlighted Wise County, Virginia as an example of gaps in access to care for non-hospital services and misplaced resources.[17] Wise County has a population of 47,000 people that is steadily declining - yet there are three full service hospitals in the county, each with a census below 30. The reporter told the story of uninsured patients with chronic health conditions who aren't able to access the primary care services they need. Resources that could be spent on lower cost primary care and disease management initiatives are tied up in three acute care hospitals. How does this happen? Unfortunately, the incentives are improperly aligned. Today, hospitals in Wise County, and many other rural areas, are incentivized to provide acute care services, invest in physicians who perform high-cost procedures, and expand services for competitive reasons, even if they are duplicative. Yet, the fundamental health care needs of the population are not being met. The resources are there, but there is no organized incentive to change the model to address the needs of the region. The COPA creates this incentive. By eliminating irrational competition, the New Health System will be able to reduce unnecessary cost, and refocus its resources to provide access for the medically underserved. Shifting physical resources and personnel to needed outpatient services (including mental health and substance abuse services), case management services, and health management services will ultimately result in a healthier population and contribute to economic improvement, including a more sustainable health care workforce and a more employable overall workforce.

Background: Populations are medically underserved in this region for lack of insurance and lack of providers. Wellmont and Mountain States currently provide significant amounts of charity care to uninsured and underinsured populations in the Geographic Service Area[18] and will continue to do so in the future in accordance with IRS guidelines for not-for-profit hospitals. In fact, the New Health System's charity care policy will increase the benefit for charity care above and beyond what either of the Parties currently provide. The new policy will provide a 100%

[17] *See On the road with the Health Wagon*, 60 Minutes, March 24, 2016, available at: http://www.cbsnews.com/videos/on-the-road-with-the-health-wagon (accessed July 10, 2016).

[18] In fiscal year 2015, Wellmont provided $72,940,011 in uncompensated care. See Wellmont's IRS Form 990 for fiscal year 2015.

discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the Federal Poverty Level, with a sliding scale applying to certain patients.

The New Health System will take other steps to benefit needy patients. One of the New Health System's stated goals is to reduce unnecessary utilization of high cost emergency department and inpatient services by uninsured individuals. So-called "super-utilizers" of health care consume a disproportionate level of health care resources and often have co-existing medical conditions coupled with addiction and mental health issues and social resource needs.

The New Health System will design an effective case management model for this "super-utilizer" population, once identified, that is proactive. Elements of the program will include social needs screening and assessment (transportation, food and housing insecurity, high risk behaviors or environments, etc.), connection to primary care preferably in a patient-centered medical home model for disease management, connection to health care and social resource navigators and community health workers, and connection to medication assistance. The New Health System will also provide resources for individuals who are ready to receive intervention for unhealthy behaviors that contribute to poor health. Findings from previously conducted model programs will be used to inform and create the overall plan. Partnerships with regional Federally Qualified Health Centers, Rural Health Centers, Health Departments, and charity clinics will be essential.
For individuals who agree to comply with certain requirements such as following physician prescriptions and orders, keeping scheduled appointments, participating in appropriate screenings, and participating in education related to chronic conditions or healthy lifestyles, the New Health System will provide guaranteed access to program services and medical care and the discount for services will be increased substantially.

This model can be a precursor to other population health models which can apply to other high-utilizer populations and may even be a source for translational research studies to result in best practice program development—especially in rural environments. The Parties believe this is a significant advantage that will offset any potential disadvantage that results from the reduction in competition. Reduced pricing and improved quality and access to services are key to this particular commitment.

Both systems also subsidize physicians, services and facilities in areas that lack medical care. But there are still considerable unmet needs. As neither Tennessee nor Virginia is a Medicaid expansion state, the number of uninsured will persist and as high deductible health plans grow, the number of effectively under-insured will continue to rise beyond current levels.

As far as services, mental health, substance abuse and specialty pediatric services are three areas the Parties have identified as priority for investment. These services have not been developed for two primary reasons: first, because patient volumes are disaggregated between the two health systems, and neither system has the critical mass necessary to support the service, and second, because the size of the serviced population is not sufficient to fully support full-time specialists.

Assessment: To address the uninsured populations that need access to affordable health care, will comply with all state and federal regulations in regard to charity care and essential hospital access and will be consistent with the New Health System's role as a public benefit, not-for-profit, tax-exempt corporation. The new policy will provide a 100% discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the Federal Poverty Level, with a sliding scale applying to certain patients.

Uninsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that Section, governing not-for-profit organizations, and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible.

As detailed in the Application, the New Health System intends to partner with, or support, existing community based charity clinics along with rural health clinics and Federally Qualified Health Centers ("FQHCs") to help people access the care they need rather than creating new charity clinics. There are many effective charity care clinics and programs already operating in the region, and the New Health System believes that partnering with or supporting these established programs will be the best use of community resources. An established network of care options will be especially important as the New Health System seeks to enroll indigent or uninsured high-use, high need individuals in the "super-utilizer" accountability model mentioned in Response #7. Under this program and the regional network of primary care providers, the New Health System will encourage individuals to participate more actively in their health and to employ prevention and disease management strategies so that high cost health care utilization can be avoided. Effective management of the health of this population in partnership with charity care clinics and FQHCs along with social agencies and others will reduce the cost of health care in the region overall and allow the New Health System to keep costs lower for everyone. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

The uninsured population will also be the target of several inter-related health strategies outlined in the Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the service area – Wellmont currently holds an active federal grant for these navigator services, Mountain States does not.

In addition, the proposed partnership is committed to efforts to improve overall health services to the medically underserved areas. In cooperation with the College of Public Health at East Tennessee State University ("ETSU"), the Parties launched the region's most substantial community health improvement assessment effort to date. Four Community Health Work Groups were created to specifically focus on medical needs of the medically underserved,

identify the root causes of poor health in this region, and identify actionable interventions the New Health System can target to achieve a generational shift in health trends. The Parties jointly sponsored and funded these four Work Groups only as part of the Parties' goal to improve health care services through the Cooperative Agreement.

The Community Health Work Groups met during the Fall of 2015 in public meetings throughout Northeast Tennessee and Southwest Virginia to seek community input. The meetings were led by subject matter experts and included business and community leaders from throughout the region who represent a broad variety of experience and perspectives. The meetings were also staffed by members of Mountain States and Wellmont along with master's and doctoral-level students from ETSU. ETSU was engaged jointly by the Parties to analyze the community input received at these Community Health Work Group meetings and to develop a 10-year plan for addressing these community health opportunities for improvement.

As key access points increase, the Parties expect additional utilization from medically underserved populations to increase also. Additionally, as the New Health System's charity care policy becomes more generous and more widely known, the New Health System will be able to engage with the uninsured population in a way that proactively connects people to services – including primary care, health management services, and social needs navigation functions. While utilization is expected to increase overall, the Parties do expect there to be a shift, however, from higher cost inpatient and emergency department use to lower cost outpatient use and utilization of health management services.

Recommendation: The Cooperative Agreement will allow the hospitals to redirect efficiencies to continue to support programs and services that do not currently exist or are now unprofitable and otherwise may have to be reduced or cancelled due to lack of funding. To ensure the merger results in improved access to health care for the medically underserved under the Cooperative Agreement, Wellmont and Mountain States have proposed the following commitments to be included in the COPA and actively supervised by the state:

- The New Health System commits to spending at least $140 million over ten years pursuing specialty services as detailed below which otherwise would not be sustainable in the region without the financial support of the transaction.
- The New Health System commits to creating new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
- The New Health System commits to ensuring recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.
- The New Health System commits to development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients' homes as possible.
- The New Health System commits to development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.

- Implementation of an organized care delivery model for the uninsured which would provide significantly higher pricing discounts to individuals who agree to participate meaningfully in an organized accountability model which guarantees access and lower pricing in return for improved individual health behaviors among the uninsured population.

(H) Any other benefits that may be identified.

Situation: In addition to the benefits identified above, Wellmont and Mountain States expect the Cooperative Agreement to result in additional benefits for the region. These benefits will include: increased behavioral health and substance abuse services, enhanced health IT capabilities, robust academic and research partnerships, and a commitment to workforce development. The Parties will be held accountable for their commitments through the COPA.

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

Assessment: In addition to the other benefits listed above, Wellmont and Mountain States expect the Cooperative Agreement to result in the following benefits for the Geographic Service Area:

- Behavioral Health and Substance Abuse Services. Behavioral health and substance abuse issues are a major health factor in the geographic area served by the Parties, and there are currently significant gaps in the continuum of care related to these issues. As part of the public benefit associated with the merger, and the $140 million commitment, the New Health System is prepared to make major investments in programs and partnerships that will help to address these issues. The societal cost associated with mental illness and substance abuse is extensive, and, given that the single largest diagnosis related to regional inpatient admissions is psychoses, these issues merit priority attention. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thereby contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to support the development of effective behavioral health and substance abuse resources to provide high-quality, well-coordinated, and more proactive care.

The Parties recognize that important relationships must be developed across a continuum of community-based resources, primary care, intensive outpatient care, and inpatient care. In fact, effective systems of care and provider resources in the outpatient environment and the community will contribute to reducing the need for acute hospitalization or emergency department use. Though the New Health System will work to ensure appropriate inpatient resources exist, the main focus of development in this area will be outpatient systems of care, coordinated systems of care in the community, sufficient provider and specialized counseling resources, and residential recovery services. The New Health System will work within the existing framework of resources and partnerships across the region to identify needs associated with this area as well as gaps in service offerings. The Parties expect to identify a more integrated care model similar to what is outlined by the Agency for Healthcare Research and Quality ("AHRQ") for the region through the efforts of the Community Health Work Groups. That model includes primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care addressing mental health, substance abuse conditions, health behaviors, life stressors and crisis, stress-related physical symptoms, and ineffective patterns of health care utilization. The work of AHRQ and other evidence-based best practices will be used as a guide to support the development of regional services in a model that is coordinated, co-located, and integrated to overcome the disparate and disconnected manner in which individuals are currently treated. The New Health System will support a network of care resources across the region in partnership with agencies such as Frontier Health, Highlands Community Services, the regional rural health centers and Federally Qualified Health Centers, faith-based organizations, and health departments. Together with these partnership networks, the care resources associated with the New Health System, including primary care networks, emergency department networks, and inpatient behavioral health, will position the system to positively impact the development of this continuum of resources in an unprecedented way.

- Enhanced Health IT Capabilities. The Cooperative Agreement will allow the New Health System to leverage its integrated technology systems, combined with data from within the community to better coordinate population health efforts. By creating a "single team" approach, the combined system will promote collaboration across inpatient and outpatient care environments, engage patients, and manage health care data to promote healthier living and manage chronic care conditions.

- Academic and Research Partnerships. A hallmark initiative enabled by the proposed merger is the development of an enhanced academic medical system which can help transform health care delivery and address health care needs, access, experience, and economic well-being of the local community in the near term as well as long term. The proposed merger provides funds generated through merger efficiencies, some of which the Parties will invest in the development of research and academic enhancement to bring specific health care and economic benefits to the community. The Parties intend for the academic health system to be a focal point for health care and population health research specific to the issues and needs of the communities served by the New Health System in Tennessee and Virginia to focus strategies for interventions and improvements in health and health care delivery. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty,

expanded services and training can also contribute to the economic vitality of the area as well as the improved ability to attract medical professionals and business endeavors, thereby benefiting the communities with overall health and economic wellbeing.

- Workforce Development. In addition to developing academic and research programs that attract talent to the region, the New Health System intends to attract and retain employees by being competitive with neighboring health systems. The Parties believe that by carrying through on the commitments in the Application, the New Health System will become a nationally recognized model which will attract highly talented team members and physicians who want to be part of a health care solution not necessarily offered elsewhere.

Recommendation: Wellmont and Mountain States anticipate significant benefits from the merger, including increased behavioral health and substance abuse services, enhanced health IT capabilities, improvement in the quality and availability of health care services, robust academic and research partnerships, and a commitment to workforce development. To ensure these benefits outweigh any potential disadvantages associated with the transaction, Mountain States and Wellmont make the following commitments:

- Behavioral Health and Substance Abuse Services
    - As part of its $140 million commitment, the New Health System will create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region. This service is not broadly available without sufficient capacity, and there are no plans by any entity to develop and build an integrated residential treatment facility. This benefit would not occur but for the transaction.
    - The New Health System will develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements.
- Enhanced Health IT Capabilities
    - The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.
    - The New Health System will commit to participate meaningfully in a health information exchange open to community providers.
- Academic and Research Partnerships
    - The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.
    - With its academic partners in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, physician assistants, and other allied health professionals in the region.
    - The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan

for investment in research and growth in the research enterprise within the region.

- Workforce Development
    - The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.
    - The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.
    - The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

Potential Disadvantages of the Proposed Merger

The department's evaluation of any disadvantages attributable to any reduction in competition likely to result from the agreement shall include, but need not be limited to, the following factors:

(A) The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed healthcare organizations, or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals, or other healthcare providers;

Background: Depending on the facts, mergers can "enable the merged firm to reduce its costs and become more efficient, which, in turn, may lead to lower prices, higher quality products [or services], or investments in innovation."[19] Tennessee's COPA law recognizes these principles as they apply to healthcare mergers through the list of potential advantages identified in the statute. Also under certain facts, mergers can result in market power, which can be exercised by raising price, reducing quality or slowing innovation.[20] The COPA law's list of potential disadvantages reflects this principle as well.

Assessment: While anticompetitive effects may be a disadvantage resulting from some unregulated mergers, even if such effects were otherwise likely here, the Legislature, through the COPA, as implemented under the Rules, provides the Department with an effective means to address this potential disadvantage by actively supervising the payer contracts entered into by the merged entity.

The major payer mix for the proposed Geographic Service Area of the New Health System (Application Exhibit 5.1-C) is:

Medicare	38.6%
Medicaid	17.0%
Medicare Advantage	14.7%
Commercial	17.5%
Self-Pay	6.2%

Because fee-for-service Medicare and Medicaid payments to hospitals are established by formula and largely unaffected by price competition, the principal category of payers that could potentially be disadvantaged by a merger are commercial health plans and their enrollees (including Medicare and Medicaid managed care). These payers also represent a substantial share of total enrollment in the Tennessee and Virginia service area, respectively. As such, it is important for the Parties to be included in contracts with each of these payers.

The combined inpatient share in the proposed Geographic Service Area for the New Health System is approximately 73 percent. The combined facilities share for outpatient services (Application Exhibit 6.1-A to 6.1-D) ranges between 0 percent and 55.6 percent depending on

[19] Commentary on the Horizontal Merger Guidelines, Federal Trade Commission and U.S. Department of Justice (2006) at 1, available at https://www.ftc.gov/sites/default/files/attachments/merger-review/commentaryonthehorizontalmergerguidelinesmarch2006.pdf.
[20] Id.

the specialty. Combined, the New Health System will employ approximately 30 percent of the physicians in the proposed Geographic Service Area (Application Exhibit 6.1-E).

The Parties recognize that absent the active supervision of a COPA, there is a concern that the New Health System could potentially be able to obtain increased prices from non-governmental payers for whom prices are subject to negotiation. The Parties believe that the current and future market conditions in which the New Health System operates impose both substantial constraints on their pricing and quality and incentives to achieve improved outcomes. Among these are the relatively small proportion of patients covered by commercial contracts relative to Medicare, Medicaid, and other non-commercial or uninsured business, and the substantial share of enrollment held by the New Health System's largest two payers. The New Health System will have every incentive to negotiate with these payers in order to be able to attract patients and avoid loss of patients to other hospitals. In addition, as noted elsewhere, the Parties have committed to invest significantly in the communities in which they operate in the form of new services, enhanced services and locations, programs and initiatives to improve population health, and targeted investments on the highest priority health issues. These provide the incentive to achieve efficiencies and to improve health and outcomes, so as to sustain investments.

Nonetheless, there are certain mechanisms that the Parties have proposed that could be adopted by the State to actively supervise the payer contracts entered into by the merged entity to address this potential disadvantage.

Recommendation: In order to prevent the New Health System's ability to exercise any increased market or bargaining power achieved through the merger that could adversely impact the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals or other healthcare providers, the Parties have proposed that the following commitments be included in the COPA and be actively supervised by the State:

1. *The New Health System will negotiate in good faith with Principal Payers[21] to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates (subject to the limitations herein). The New Health System would agree to resolve through mediation any disputes in health plan contracting.*

   How this commitment would prevent the potential disadvantage: This commitment by the New Health System would prevent the New Health System from rejecting in-network participation for payers constituting more than two percent of the New Health System's revenue if terms and rates offered were commercially reasonable (a judgment itself subject to the State's active supervision). Because the New Health System would be required to negotiate in good faith with all Principal Payers who offer commercially reasonable terms, or risk violation of the terms of the COPA, the New Health System

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

would have no leverage to demand anticompetitive rates. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA. In addition, any disputes in health plan contracting between the New Health System and the Principal Payers would be subject to mediation. Mediation consists of confidential negotiations facilitated by a third-party neutral whose role is limited to helping parties arrive at a mutually agreeable resolution to the dispute. Mediation is less expensive than litigation and less time-consuming. The Parties believe the commitment to mediation will help expeditiously resolve any disputes that arise with Principal Payers in order to minimize the impact a dispute may have on covered beneficiaries.

2. *The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.*

   How this commitment would prevent the potential disadvantage: This commitment would prevent the New Health System from requiring payers to contract with the merged entity exclusively in the proposed Geographic Service Area. The result is that consumers will continue to have network choices beyond the New Health System and providers will have an alternative to contracting solely with the New Health System or its network. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

3. *The New Health System will not engage in "most favored nation" pricing with any health plans.*

   How this commitment would prevent the potential disadvantage: A most-favored-nation clause is any term in an agreement between a payer and a provider that stipulates that either a) the provider give the payer the lowest rate that it contracts with any comparable payer or b) the payer must give the provider the highest rate that it contacts with any comparable provider. This commitment will preclude the New Health System from obtaining a promise from a health plan that it will be paid as much as, or more than, any other provider with which the health plan contracts. Such a commitment controls the New Health System's ability to exercise any alleged market or bargaining power achieved through the merger to require payers to pay them the highest price available in the market. Alternatively, where a large payer may require the lowest possible rate contracted in the market from the New Health System, this commitment would prevent a scenario whereby the New Health System is reluctant to offer discounts to other payers. Such activity could prevent other, possibly more competitive, payers from effectively competing in the market. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

The Parties believe that including these commitments in the COPA will prevent the New Health System from exercising any possible market or bargaining power achieved through the merger to adversely impact the ability of health maintenance organizations, preferred provider

organizations, managed health care organizations or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals or other healthcare providers. The Parties presume that, to ensure the disadvantage is prevented, the State will actively supervise these commitments through annual reporting requirements.

(B) The extent of any reduction in competition among physicians, allied health professionals, other healthcare providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the cooperative agreement;

Background: Depending on the facts, consolidation between health system competitors could result in a net benefit for patients, employers and payers by fostering integrative efficiencies, realignment of resources and improved opportunities for value-based care and population health improvement. In a given case, the elimination of competition between merging parties could also facilitate market power to engage in exclusionary practices that foreclose other healthcare providers or suppliers from access to the market and lead to increased prices for consumers.

Assessment: Although the merger will eliminate competition between the Parties, the COPA is the mechanism created by the Legislature to allow beneficial mergers while ensuring through active state supervision that consumers retain those benefits. Through this statutory authority, the State is able to protect its citizens from anticompetitive activity and simultaneously allow the New Health System to address the region's major population health issues and related healthcare challenges.

As noted above, the combined facilities share for outpatient services (Application Exhibit 6.1-A to 6.1-D) ranges between 0 percent and 55.6 percent depending on the specialty. Combined, the New Health System will employ approximately 30 percent of the physicians in the proposed Geographic Service Area (Application Exhibit 6.1-E). The merger of Mountain States and Wellmont will not create a concentrated market involving any physician or outpatient services. The Parties acknowledge that for general acute care inpatient services, the merger creates a relatively concentrated proposed Geographic Service Area.

Without active supervision under the authority of the COPA law, it is possible the merger would empower the New Health System through exclusionary practices to foreclose market access by physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals. There are, however, certain mechanisms that the Parties have proposed that could be adopted by the State to actively supervise the merger and ensure that consumers reap the expected benefits of higher-quality, more affordable care from the merger.

Recommendation: In order to prevent the New Health System from reducing competition among or for physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals in a way that results in disadvantages, the Parties have proposed that the following commitments be included in the COPA and be actively supervised by the State:

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

   How this commitment would prevent the potential disadvantage: A commitment to maintain an open medical staff at all facilities will ensure equal access to all qualified physicians in the proposed Geographic Service Area according to the criteria of the medical staff bylaws. This will ensure that independent physicians who meet the rules and conditions of the organized medical staffs of each facility will not be disadvantaged compared to physicians employed or contracted by the New Health System. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

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

   How this commitment would prevent the potential disadvantage: Independent physician practices frequently depend on the ability to see patients at multiple facilities to provide services or manage populations for whom they've assumed risk. A commitment to abstain from exclusive contracting for certain non-hospital-based physician services will enable independent physician practices to continue to compete with physicians employed or contracted by the New Health System. The New Health System will restrict any exclusive contracting to certain hospital-based physicians, like hospitalists, radiologists, pathologists, or emergency-room physicians, as approved by the Board of Directors. The best practice in the industry for preserving quality and managing cost in these hospital-based departments is for such services to be managed by a single physician group, with such group being held to standards determined by the leadership of the hospital in collaboration with the group. As an example, it would not be optimal for a hospital to have multiple ER physician groups staffing the ER, laboratory or radiology, as doing so would risk confusion and lack of consistency in processes. This is why exclusive contracts for hospital-based physicians are common in hospital markets of any concentration level. For independent physician groups that provide hospitalist services, the New Health System will continue to allow the independent physicians or their hospitalists to follow their patients in multiple hospitals as long as the independent physicians meet the organized medical staff rules and conditions and the metrics related to performance on which the hospital and independent practice agree. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the State through annual reports attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

3. *Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.*

   How this commitment would prevent the potential disadvantage: Exclusive contracting has the potential to reduce competition by requiring physicians to render services only at facilities of the New Health System. Restricting the practice of independent physicians

to the New Health System's hospitals and other facilities has the potential to reduce the number of referrals in the proposed Geographic Service Area available to competing providers, and reduce the labor supply of physicians necessary for these providers to operate in the market. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the State through annual reports attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

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

   How this commitment would prevent the potential disadvantage: Prohibiting or disincentivizing independent physicians from participating in health plans and provider networks of their choice has the potential to reduce competition and raise prices for insurers contracting to form provider networks. A commitment to not engage in such practices (be they as conditions for obtaining privileges or for other reasons) ensures continued competition among health plans and providers. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the State through annual reports attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

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

   How this commitment would prevent the potential disadvantage: A health information exchange built off a Common Clinical IT Platform has the potential to improve coordination of care and quality of health care services across the region. To ensure that independent physicians and other health care providers in the proposed Geographic Services Area will not be disadvantaged by lack of access to patient information necessary for the management of their patients, the New Health System has committed to participating in a health information exchange open to community providers. The New Health System will ensure its Common Clinical IT Platform interfaces appropriately with the exchanges designed to share health information such that data may be shared with physicians. Additionally, the New Health System will utilize the data for its own employed physicians and service locations where the use of this data will enable improvement in the coordination of care. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance once the health information exchange is fully established and the State would have the ability to enforce this commitment under the COPA.

6. *The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.*

   How this commitment would prevent the potential disadvantage: A health system that achieves increased market share or bargaining power through a merger could potentially obtain labor at more favorable terms and wage rates than in an otherwise competitive market for the purchase of labor. Such an outcome is not likely for the New Health System due to at least two factors, in addition to this commitment: 1) the low

area wage index that the region is currently assigned by the federal government creates competition for labor from outside the Geographic Service Area, and the merger will not reduce this competition 2) the New Health System will not have a dominant share in the outpatient and physician services market which are attractive alternative employment options for hospital staff.

To further ensure that employees are not disadvantaged by the loss of competition between the Parties, the New Health System will commit to honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave. This commitment would be actively supervised by requiring the New Health System to file a report to the State attesting to compliance after the first year after formation of the New Health System and the State would have the ability to enforce this commitment under the COPA.

The Parties believe that including these commitments in the COPA will prevent the New Health System, were it to obtain market power through the merger, from exercising it to reduce competition among or for physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals. To ensure the disadvantage is prevented, the Parties propose that the State actively supervise these commitments through annual reporting requirements.

(C) The extent of any likely adverse impact on patients in the quality, availability, and price of healthcare services; and

Background: Depending on the facts, consolidation in healthcare markets can lead to substantial cost savings by eliminating costly duplication of services and equipment and improving quality of care. These benefits can manifest from an increase in the volume of services and ability to provide expanded and coordinated health care services throughout the region. Facts in a particular case can also show that such benefits are unlikely or insufficient to offset anticompetitive effects resulting from the elimination of competition between the parties. If population stagnation continues for the next five years, as current population trends indicate, the reduced inpatient use rates and the downward pressure on reimbursement combined with the financial realities rural hospitals in both systems are facing, it is more likely that not consolidating will would have an more adverse effect on both quality and access in those markets and be an outcome far inferior to the merger governed by a COPA. As stated in this Response, the Parties' rural hospitals are in peril, and the evidence shows that rural hospitals in general are at risk, especially in markets with declining population. As use rates decline for the larger tertiary hospitals - hospitals that also operate in markets experiencing population stagnation - it is increasingly unlikely that financial support for these rural hospitals can continue at the current rate. This will lead to reduced capitalization in those markets, and quality and access are likely to suffer. Conversely, as demonstrated within the multiple commitments being made within the Application, it is more likely that quality, availability and reduced pricing will only result from the approval of the COPA. Reduced pricing will occur for the uninsured through additional discounts on pricing in return for participation in organized care managed models of guaranteed access. Importantly, pricing will actually increase more for the insured population if the COPA is not granted, given the commitment to reduce pricing growth already agreed to by payers, and subsequent limits on pricing growth thereafter.

Assessment: The merger will result in the consolidation of some services between the Parties, but not in any adverse impact on the quality, availability or price of healthcare services. The merger creates the opportunity to achieve significant cost-savings and other benefits for consumers. Active supervision through the COPA can preserve, and hold the New Health System accountable for enhancements in healthcare quality, cost-control, affordability, and access. Additional external pressures are also being placed on the health system to improve quality and reduce cost as well. For example, the Centers for Medicare and Medicaid Services has announced the imposition of value based purchasing and quality-based incentives and penalties for hospitals, which currently are focused on reduced readmissions, hospital acquired conditions, patient satisfaction and literally dozens of metrics which tie quality to reimbursement. Because the hospitals do not segregate populations as they work to comply with these mandates, all patients, regardless of payer, benefit from these efforts. Commercial, Managed Medicaid, and Medicare Advantage contracts are also significantly invested in pay-for-performance, and, in addition to active supervision, the New Health System will be held, through financial incentives and penalties, to achieving the objectives agreed to by the payer and the system. In addition, for the New Health System to achieve the expenditure commitments being made in the Application, pressure will exist to achieve the synergies committed in the Application. Significant competition will remain from large tertiary systems located nearby requiring the New Health System to continue to behave competitively to attract patients. Competition will remain locally in the outpatient marketplace. As a locally governed enterprise, accountability to the community will be an important advantage over the elimination of local governance which would occur if one or both of the Parties were to join out-of-market systems based elsewhere.

Therefore, as courts have recognized, the major changes occurring in the health care landscape require health systems to behave differently and to be responsive to these payer and government imposed performance standards. The consolidations occurring due to the merger better enable the system to achieve these objectives through improved efficiency, lower cost, and a refocusing of resources on the clinical integration necessary for success.

Recommendation: In order to prevent the New Health System from adversely impacting the quality, availability and price of healthcare services, the Parties have proposed that the following commitments be included in the COPA and be actively supervised by the State:

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

   How this commitment would prevent the potential disadvantage: In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. This commitment ensures that the three hospitals which have traditionally served as the hubs for high-level services, Johnson City Medical Center, Bristol Regional Medical Center and Holston Valley Medical Center, will remain available as tertiary referral centers to the patient population. This commitment would be actively supervised by requiring the New Health System to file an

annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

2. *Maintenance of open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors*

   How this commitment would prevent the potential disadvantage: Under the current competitive system, patient choice is limited by restrictions on employed physicians' ability to practice at competing system's hospitals in the Geographic Service Area. With some exceptions, Wellmont-employed physicians are not allowed medical staff privileges at certain Mountain States hospitals and Mountain States-employed physicians are not allowed medical staff privileges at certain Wellmont hospitals. This is particularly true in highly competitive specialties such as cardiology. This practice exists because of competitive factors and does not support convenient access for patients. Not only will the New Health System maintain open medical staffs at all facilities, which allows patients to choose a physician and hospital based on their preferences and needs, but employed physicians will now be able to practice at all facilities within the New Health System subject to the rules and conditions of the organized medical staff of each facility. A commitment to maintaining an open medical staff at all facilities will ensure availability to all qualified employed, contracted or independent physicians in the proposed Geographic Service Area according to the criteria of the medical staff bylaws. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

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

System and a Principal Payer are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.

How this commitment would prevent the potential disadvantage: Without a commitment to cap rate increases, the New Health System could potentially use any marketing and bargaining power achieved through the merger to increase rates for payers and consumers. In order to prevent any potential disadvantage that may result for the patients and payers in the price of healthcare services, the Parties have proposed an initial rate reduction followed by a rate cap commitment to be supervised by the State. Reducing existing commercial and Medicare Advantage contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System will lead to a reduction of prices for consumers and payers below that which is currently agreed to in contracts between Wellmont and its payers and Mountain States and its payers. The commitment of not increasing hospital, non-hospital and physician services rates greater than their respective Consumer Price Index minus 0.25% will bend the price curve, acting as a maximum cap on price growth always lower than the national average. To ensure this commitment is implemented, the State would actively supervise the rate cap implementation and the New Health System would be required by the State to file an annual report attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

4. *The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.*

   How this commitment would prevent the potential disadvantage: Many of the commitments in the Application will allow the New Health System to achieve success as federal, state and commercial payers increase their use of value-based payment. Among others, these include a common IT platform, more concentrated volumes, a goal of top decile performance, and a commitment to move toward risk-based models. Without the transaction, and with decreasing volumes and use rates (and thus an increasing inability to financially support many of the hospitals), it will simply be more difficult for these hospitals to achieve the objectives of the government and commercial payers.

   To ensure that a reduction in competition between facilities does not decrease the incentive for increased quality and value of care, the Parties have committed to seeking out the alignment of reimbursements with quality and value measures. Federal and state governments are increasingly tying reimbursement, and reimbursement growth, to performance by measuring quality, patient experience and utilization/total cost of care. Commercial health plans and managed Medicare and Medicaid plans are following Medicare's lead. Not only will increased value based payments limit the ability of the New Health System to increase price based on a dominant market position, these payments will drive the New Health System towards improved quality and enhanced patient experience. Since an increasing number of payers with value-based systems

reward appropriate utilization, it will be difficult for the New Health System to make up lost revenue from the price controls detailed above in Section C.3 by inappropriately increasing utilization. *This commitment ensures that the New Health System will actively pursue quality and value based payments* and the State will actively supervise this commitment by requiring the New Health System to report progress toward this goal on an annual basis.

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

   How this commitment would prevent the potential disadvantage: To further ensure that a reduction in competition between facilities does not decrease the quality of care in the region, the Parties have proposed a commitment to report quality measures in a timely and easy to understand manner for use by patients, employers and insurers. Public and proprietary reporting of quality data is increasingly being used by patients, employers and insurers to make decisions about what providers provide the best value. Not only are patients utilizing data on quality to decide what provider to use, employers and insurers are increasingly using similar quality data to decide how to tier or narrow their networks to incentivize the use of high-value providers or to exclude low-value providers all together. This commitment ensures that the New Health System will be held accountable by the State and the public for its quality performance. The State will actively supervise this commitment by requiring the New Health System to comply with its quality reporting obligations on an annual basis.

(D) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement.

Background**:** Some may argue that partial integration through a joint venture creates benefits in a less restrictive manner than a merger that poses competition concerns. It is true that the partial integration preserves competition between the parties outside the joint venture, but it also typically generates substantially smaller efficiency and quality benefits than a full merger. Under a COPA, structures are in place to ensure that the merger's benefits continue to outweigh the disadvantages resulting from the loss competition.

Assessment: The potential efficiencies and benefits identified in this Application could not be achieved without the merger and granting of a COPA. Moreover, the commitments relating to pricing, consolidation of services, and standardization of practices and procedures would raise significant antitrust concerns if undertaken together by two independent hospital systems. Alternatives that opponents may consider less restrictive to competition, but produce fewer benefits and several disadvantages than a COPA, are discussed below:

Status Quo. The two systems could continue to compete with each other, which is the status quo. However, in a Geographic Service Area that has one of the lowest Medicare Wage Indices in the country, negligible population growth and contains fourteen Health Professional Shortage Areas,[22] the status quo has produced a combined debt service of

[22] See http://www.hrsa.gov/shortage/mua/index.html.

$1.5 billion, bond ratings below A grade, and significant restrictions on the availability of capital to invest in the upkeep of existing infrastructure. With a continued decline in the rate of hospital admissions per capita, the status quo alternative is likely to result in significant reductions in staff, services, and rural facilities to maintain operating margins. While maintaining the status quo may be less restrictive to competition, it would not result in any of the benefits that would be made possible by the merger if the COPA is granted. In fact, maintaining the status quo is likely to result in significant disadvantages for the community and the health of the region.

Joint Ventures: Most of the efficiencies identified by the New Health System could not be undertaken under Joint Venture arrangements. Because integration would be partial, not full, meaningful reduction in unnecessary duplication, and the cost-savings and other associated benefits of the merger, would be sharply limited. To the extent there is integration, the Parties would need to share proprietary information, requiring the setting up of complex firewalls and other protections to protect against spillover of competitively sensitive information into areas outside the joint venture. In the past, the Parties have attempted to collaborate with respect to quality improvement methodologies and related projects, but these efforts have been unsuccessful due to the restrictive competitive environment. Specifically, the Parties, as competitors, have been unable to share proprietary information and have lacked a common clinical information system. A joint venture would eliminate the incentive for the Parties to move towards a Common Clinical IT Platform due to the significant investments both Parties have made towards their individual IT systems. Commitments relating to pricing, consolidation of services, standardization of practices, and procedures, would also raise significant antitrust concerns if undertaken together by two independent hospital systems in a joint venture arrangement. The Parties have exhausted their joint venture options in the current competitive market. As a result, the COPA is needed for the Parties to realize the benefits made possible by the merger.

Out-of-Market Merger. Finally, the Parties wish to address the alternative of a merger by either Party with an out-of-market health system. While such a merger with a third-party is not a current alternative, it has been raised by opponents as less restrictive to competition than the merger between Wellmont and Mountain States.

The impetus behind the proposed merger of Wellmont and Mountain States was the independent decision of the Wellmont Board of Directors that Wellmont must merge with another system or be acquired in order to be successful long-term. This decision led to the search for a strategic-partner. The Board of Directors of Mountain States subsequently recognized that if Wellmont merged with an out-of-market entity, Mountain States would need to do the same in order to stay competitive against a better capitalized competitor.

If Wellmont and Mountain States are not allowed to merge under the COPA, both systems would continue their independent searches for partners outside the region. A merger by either Party with an out-of-market system would not require a COPA and would likely not trigger the same antitrust scrutiny. In this case, there is a reasonable concern that a merger by either Party with an out-of-market system could result in price

increases for consumers since the out-of-market partner would be free to leverage any bargaining position without State supervision.[23]

Other deleterious effects could result from the merger by either Party with an out-of-market system. Specifically, local governance over health care operations would likely be lost. Well-paying jobs in the region may decrease as corporate business functions would be eliminated locally and centralized out-of-market. Any efficiencies gained from an out-of-market merger would likely be sent out of the region to two new corporate parents instead of being reinvested in public health, behavioral health, and academics and research as the Parties have committed to under the COPA. Finally, a merger with an out-of-market system by either Party would likely result in the potential loss of access to health care in rural areas. As described in the Application, providing services in rural areas is often unprofitable, and it would be very difficult to maintain rural healthcare services in the long term without the commitments made by the two Parties under the COPA. In short, while a merger by either Party with an out-of-network system may be viewed as a less restrictive alternative to the merger of Wellmont and Mountain States, none of the benefits or efficiencies described in the Application would be likely to result from such an out-of-market merger. In fact, the unsupervised merger of either Party with an out-of-market system is likely to result in far more disadvantages for consumers and the community than a merger of Wellmont and Mountain States that is actively supervised by the State.

Recommendation: The many benefits of the merger between Wellmont and Mountain States that are articulated in the Application would not be possible without the non-labor, labor, and clinical efficiencies available as a result of the combination of local resources owned by Wellmont and Mountain States. Since the proposed consolidation of local assets would likely implicate state and federal antitrust laws without a COPA, there is no less restrictive arrangement that would result in the same, or even similar, benefits. The Parties have already exhausted their joint venture opportunities in the current competitive environment. Maintaining the status quo or pursuing a combination with an out-of-market system is likely to result in far more disadvantages to consumers and the community than an actively-state-supervised merger. As a result, there are no arrangements available that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the merger of Wellmont and Mountain States.

The COPA provides a unique mechanism for Wellmont and Mountain States to merge under active state supervision. This structure allows the State to replace competition with regulatory oversight of the New Health System's compliance with the mutually agreed enforceable commitments that benefit the community. Ongoing, active supervision by the State ensures that the benefits of the merger continue to outweigh any potential disadvantages and that the State's policies underlying the issuance of the COPA are fulfilled.

[23] See, e.g., Dafny, L., Ho, K., and Lee, R.S. "The Price Effects of Cross-Market Hospital Mergers." Working Paper, 2015 for discussion of these issues.

Exhibit 11

List of Wellmont's Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue

CONTRACT LISTING - Less than 2% Net Revenue

CONTRACT	CONTRACTING PARTY
Aetna	PHO
Amera-Net	PHO
American PPO	PHO
Amerigroup	WHS (System)
Anthem Healthkeepers HMO SNF	MVRMC
Anthem Med Advantage SNF	MVRMC
Anthem PAR/PPO SNF	MVRMC
Anthem	Hospice
BCBST TennCare	ASC's
BCBST TennCare	WHS Hospitals
BCBST Medical Service Agreement	Hospice
BCBST TennCare	Hospice
Beacon Health (Value Options)	BRMC/Ridgeview
Beech Street	PHO
Carolina Steel	PHO
Cigna Behavioral Health	BRMC/Ridgeview
Cigna Behavioral Health	WMA - contracts with each behavioral health provider
Commonwealth of VA Dept of Rehab	BR/HV/LPH/MVRMC
Corvel Corporation	PHO
Coventry Healthcare of Virginia	PHO
Coventry National Network	WHS Facilities
Employer's Choice Network	WHS Hospitals in VA
Evolutions Healthcare Systems	PHO
Galaxy Health Network	PHO
HealthNet Federal Services (Veterans)	WHS Hospitals in VA
HealthNet Federal Services (TriCare)	WHS Hospitals in VA
HealthNet Federal Services	WMA
HealthNet Federal Services	WCS
HealthSpring Medicare Advantage	Wexford House
Humana Tricare Prime	WHS Hospitals/Hospice
Humana Tricare	WMA
Humana Tricare	WCS
Integrated Medical Solutions	PHO
INTotal Health	PHO
LifeSynch	WMA
King University	PHO
Magellan Behavioral Health	BRMC/Ridgeview
MCA Level Funding Plan	PHO
MHNet Behavioral Health	BRMC/Ridgeview
Mountain Empire PACE	WHS Hospitals/Hospice
Mountain Empire PACE	WMA
Multiplan	PHO
NovaNet	PHO

Optima Health Medicaid	WHS
Optima Health Medicaid	WMA
Optima Health Medicaid	WCS
Pittston Preferred	PHO
Prime Health Services	PHO
Provider Select	PHO
Scott County School Board	PHO
SelectNet Plus	PHO
Takoma Regional Hospital	PHO
The Initial Group	PHO
The United Company	PHO
TriCare for Life	Wexford House
TriWest Healthcare Alliance	WHS (System)
United Behavioral Health Commercial	BRMC/Ridgeview
United Behavioral Health Commercial	WMA - contracts with each behavioral health provider
United Behavioral Health TennCare	BRMC/Ridgeview
United Behavioral Health TennCare	WMA
UHC Community Plan	WHS Facilities
UHC Community Plan	WMA
UHC Community Plan	WCS
UHC Community Plan	Wexford House
USA MCO	PHO
Veterans Evaluation Services	WHS Hospitals
Virginia Premier	PHO
WellCare Medicare Advantage	PHO
Wellmont Health System	PHO

Exhibit 12

List of Mountain States' Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue

Mountain States Health Alliance
Payers that Represent Less than 2% of Patient Service Revenue

Total Number of Payers **161**

Payor	Product	Mountain States Health Alliance Contracting Party
Allied National, Inc.		Mountain States Managed Care, Inc.
Amerigroup Virginia, Inc.	VA Medicaid	ISHN, LLC
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	MSHA Home Health - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	MSHA SNF - NCH & SCCH
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	MSHA Hospice - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicare Advantage	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
Anthem Health Plans of Virginia, Inc.	Medicare Integration Participation Attachment	MSHA Home Health - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicare Integration Participation Attachment	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
Anthem Health Plans of Virginia, Inc.	Medicare Integration Participation Attachment	MSHA SNF - NCH & SCCH
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	Blue Ridge
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	MSHA Home Health - VA and Kingsport Home Health

Payor	Product	Mountain States Health Alliance Contracting Party
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	MSHA Hospice - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	MSHA SNF - NCH & SCCH
Anthem Health Plans of Virginia, Inc.	VA Medicaid	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
Anthem Health Plans of Virginia, Inc.	Medicare	Blue Ridge
Anthem Health Plans of Virginia, Inc.	VA Medicaid	Blue Ridge
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	HMO Medicaid Participation Attachment – Non-Acute	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Medicare Advantage Participation Attachment – Non-Acute	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Medicare Medicaid Dual Integration	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
Appalachian Agency for Senior Citizens	AllCare for Seniors	Mountain States Health Alliance d/b/a Dickenson Community Hospital
Appalachian Agency for Senior Citizens	AllCare for Seniors	Johnston Memorial Hospital
Appalachian Agency for Senior Citizens	AllCare for Seniors	Mountain States Health Alliance d/b/a Russell County Medical Center
Appalachian Agency for Senior Citizens		Dickenson Community Hospital
Appalachian Agency for Senior Citizens		Norton Community Hospital
Appalachian Agency for Senior Citizens		Norton Community Physician Services Corporation
Appalachian Agency for Senior Citizens		Mountain States Health Alliance dba Russell County Medical Center

Payor	Product	Mountain States Health Alliance Contracting Party
Appalachian Agency for Senior Citizens		Russell County Medical Center dba Riverside Community Medical Clinic
Beech Street Corporation		Mountain States Health Alliance
Beech Street Corporation		Blue Ridge Medical Management
Beech Street Corporation		APP
Benefit Plan Administrators, Inc.		Smyth County Community Hospital
Benefit Resources, Inc.		Russell County Medical Center
Blue Ridge Job Corp Center		Smyth County Community Hospital
BlueCross BlueShield of Tennessee Inc.	Dual Eligible Special Needs Plan	Participating TennCare Provider (BRMMC)
BlueCross BlueShield of Tennessee Inc.	Dual Eligible Special Needs Plan	Participating TennCare Provider (Facilities and KDS)
Bluegrass Family Health, Inc.		Unicoi County Memorial Hospital
CareCentrix		Mountain States Health Alliance dba MCHC
Centurion		Mountain States Health Alliance
CHA Provider Network, Inc.		Norton Community Hospital
Christian Care Centers of Johnson City, Inc.		Mountain States Health Alliance
CIGNA Behavioral Health, Inc.		Mountain States Health Alliance
Commonwealth of Virginia Department of Health, Office of Family Heath Services		Smyth County Community Hospital
Commonwealth of Virginia Department of Rehabilitative Services		Smyth County Community Hospital
Commonwealth of Virginia, Department of Mental Health, Mental Retardation and Substance Abuse Services		Smyth County Community Hospital
Commonwealth of Virginia, Virginia Department of Health, Cumberland Plateau Health District	Breast & Cervical Cancer Program	Russell County Medical Center
Comp Management of Virginia, Inc.		Norton Community Hospital
Corphealth, Inc. d/b/a LifeSynch	Psych Commercial	Facility and Physician
Corvel Healthcare Corporation	Corvel Commercial/WC	Mountain States Health Alliance
Corvel Healthcare Corporation	Corvel Commercial/WC	Kingsport Ambulatory Surgery Center, LLC dba Kingsport Day Surgery
Corvel Healthcare Corporation	Physician Agreement - Commercial/WC	Blue Ridge Medical Management Corporation

Payor	Product	Mountain States Health Alliance Contracting Party
Cumberland Mountain Community Services, Dickenson County Behavioral Health Services, Highlands Community Services, Mount Rogers Community Services, New River Valley Community Services, Planning District 1 Behavioral Health Services	Psychiatric Service Agreement	Russell County Medical Center
Dickenson County Behavioral Health Services	Behavioral Health Services Agreement	Russell County Medical Center
Division of Rehabilitation Services of the Tennessee Department of Human Services		Mountain States Health Alliance
EvaluMed		Not specified; mentions “Mountain States Health Alliance physical therapist” and “Managed Care”
First Health Group Corp.		Mountain States Health Alliance - TN Facilities
First Health Group Corp.		Norton Community Hospital
Fortified Provider Network		Johnston Memorial Hospital
Frontier Health, Inc./PD 1	Psychiatric	Russell County Medical Center
Galaxy Health Network		Russell County Medical Center
Galaxy Health Network		Unicoi County Memorial Hospital
Gateway Health Alliance, Inc.		Dickenson Community Hospital, Norton Community Hospital, Smyth County Community Hospital, Mountain States Health Alliance d/b/a Russell County Medical Center (includes rates for facility and physician)
Gateway Health Alliance, Inc.		Southwest Virginia Health Network - JMH PHO(includes rates for both physicians and facility)
Grayson Nursing & Rehabilitation Center- Skilled Nursing Facility		Smyth County Community Hospital, Inc.
Health Payors Organization, LTD.		Johnson City Medical Center Hospital, Inc.
Highlands Community Services	Psychiatric	Russell County Medical Center
Holston Distributing Inc	Ancillary Agreement - WC	Mountain States Health Alliance
Horizon Health EAP Services, Inc.		Mountain States Health Alliance dba Sycamore Shoals Hospital
Horizon Health EAP Services, Inc.		Mountain States Health Alliance dba Johnson City Medical Center (dba Woodridge Psychiatric Hospital)

Payor	Product	Mountain States Health Alliance Contracting Party
Horizon Health EAP Services, Inc.		Blue Ridge Psychiatry/Woodridge Hospital Physicians
Hospice of Southwest Virginia		Smyth County Community Hospital
Humana Government Business, Inc. d/b/a Humana Military		Mountain States Health Alliance (Unicoi Locations)
Humana Health Plan, Inc.	Commercial	Mountain States Health Alliance
Humana Insurance Company, Humana Health Plan, Inc.	Commercial	Blue Ridge Medical Management
Humana Military Health Services, Inc.		Mountain States Health Alliance
Integrated Medical Solutions, LLC	USP Lee County	Mountain States Health Alliance (IPMC & NCH)
INTotal Health, LLC (formerly known as Amerigroup Virginia, Inc.)	VA Medicaid	ISHN, LLC - Physicians
ISHN - Optima/Sentara	Optima/Sentara Mediciad	Blue Ridge Medical Management
ISHN - Optima/Sentara	Optima/Sentara Mediciad	Facilities
ISHN - Optima/Sentara		Mountain States Health Alliance (Kingsport Day Surgery Center, Dickenson Community Hospital, Franklin Woods, Indian Path, Johnson City Medical, Woodridge Hospital, Johnson County Community Hospital, Johnston Memorial Hospital, Norton Community Hospital, Russell County Medical Center, Smyth County Community Hospital, Sycamore Shoals, Quillen Rehabilitation, Niswonger Children's Hospital)
ISHN - Optima/Sentara		Blue Ridge Medical Management
Ivy Hall Nursing Home, Inc.		Mountain States Health Alliance
Johnston & Associates, Inc.		Mountain States Health Alliance - WC TN & VA Diagnostic
Johnston & Associates, Inc.		Mountain States Health Alliance - TN WC Rehab
Johnston & Associates, Inc.		Mountain States Health Alliance VA WC Rehab
KDM, Inc. dba Durham-Hensley Health and Rehabilitation		Mountain States Health Alliance
Lakebridge Medical Investors, LLC dba Lakebridge Health Care Center		Mountain States Health Alliance
Magellan Behavioral Health, Inc.	Commercial	Blue Ridge Medical Management Corporation

Payor	Product	Mountain States Health Alliance Contracting Party
Magellan Behavioral Health, Inc.	Medicaid	Blue Ridge Medical Management Corporation
Magellan Behavioral Health, Inc.	Commercial	Mountain States Health Alliance
Magellan Behavioral Health, Inc.	Medicaid	Mountain States Health Alliance
Managed Health Network, Inc.		Russell County Medical Center, Inc.
Medcost,Inc.		Johnston Memorial Hospital
Medical Control Network Solutions, Inc.		Norton Community Hospital
Medical Network, Inc.		Sycamore Shoals
Mental Health Associates, Inc.		ISHN, LLC
Modern Chevrolet		Russell County Medical Center
Mountain Empire Older Citizens, Inc.	PACE	Norton Community Hospital Home Health
Mountain Empire Older Citizens, Inc.	PACE	Norton Community Physicians Services
Mountain Empire Older Citizens, Inc.	PACE	Norton Community Hospital
Mountain Empire Older Citizens, Inc.	PACE	Community Home Care, Norton Community Hospital
MultiPlan, Inc.	Commercial	Blue Ridge Medical Management
MultiPlan, Inc.	Commercial	Facility
MVP Health Plan, Inc., MVP Select Care, Inc. and MVP Affiliates	Medicare PPO	Mountain States Health Alliance and Blue Ridge Medical Management
National Preferred Provider Network, Inc.		Southwest Virginia Health Network (JMH & Physicians)
National Preferred Provider Organization (Unicare)		Russell County Medical Center & Johnston Memorial
Novanet, Inc.	Medical	MSHA Hospitals
Novanet, Inc.	Medical	KDS
Novanet, Inc.	Medical	BRMMC, Norton Community Physician Services, Abingdon Physician Partners, Dickenson Medical Associates, Dickenson Community Hospital ER Physicians, Smyth County Community Hospital ER Physicians, Smyth County Community Hospital Physicians, Russell County Medical Center ER Physicians, Russell County Medical Center Physicians, Johnston Memorial Hospital Physicians

Payor	Product	Mountain States Health Alliance Contracting Party
Novanet, Inc.	Workers' Comp	BRMMC, Norton Community Physician Services, Abingdon Physician Partners, Dickenson Medical Associates, Dickenson Community Hospital ER Physicians, Smyth County Community Hospital ER Physicians, Smyth County Community Hospital Physicians, Russell County Medical Center ER Physicians, Russell County Medical Center Physicians, Johnston Memorial Hospital Physicians
Novanet, Inc.	Workers' Comp	Kingsport Day Surgery
Novanet, Inc.	Workers' Comp	Mountain States Health Alliance
Optimum Choice, Inc		Russell County Medical Center, Inc.
Physician Services, LC	4Most Health	Facility & Physician
Pittston Coal		Russell County Medical Center
Preferred Care	USA Care Plan	Facility
Prime Health Services, Inc.		Blue Ridge Medical Management Corporation
Prime Health Services, Inc.		Facilities
Private Healthcare Systems, Inc.		Physician
Private Healthcare Systems, Inc.		Mountain States Health Alliance
Public Risk Services, Inc. /The Pool		Mountain States Health Alliance
Roan Highlands Medical Investors, LLC dba Roan Highlands Nursing Center		Mountain States Health Alliance
Russell County Detention Center		Russell County Medical Center
SelectNet Plus, Inc. (Accorida National)		Russell County Hospital
Seven Corners, Inc.	USP Lee County	Mountain States Health Alliance
Southern Health Services, Inc.	VA Medicaid	ISHN, LLC (MSHA & MSMG)
Southwest Virginia Mental Health Institute		Smyth County Community Hospital
State Of Tennessee Department of Health	Tennessee Department of Health, Communicable & Environmental Diseases and Emergency Preparedness, HIV/STD Programs , Ryan White Part B Program	Unicoi County Memorial Hospital
Tennessee Department of Health	Breast and Cervical Screenings	Unicoi County Memorial Hospital
Tennessee Department of Health	CEDEP Program (Ryan White)	Johnson City Medical Center - Facilities to be determined based on vendor forms
Tennessee Department of Health	Mammography Screening Program	Mountain States Health Alliance
The Infant Toddler Connection of Mount Rogers		Smyth County Community Hospital
The Initial Group		APP

Payor	Product	Mountain States Health Alliance Contracting Party
The Initial Group		APP
The Initial Group, Inc.		ISHN, LLC
Three Rivers Provider Network		Hospital Affiliation – Johnston Memorial Hospital
Three Rivers Provider Network, Inc.		JMH physicians
TriWest Healthcare Alliance Corp.		Mountain States Health Alliance
Trustees of the UMWA 1992 (and 1993) Benefit Plan;		Mountain States Health Alliance d/b/a Russell County Medical Center Home Health
Trustees of the UMWA 1992 (and 1993) Benefit Plan;		Norton Community Hospital
Trustees of the United Mine Workers of America Combined Benefit Fund, the Trustees of UMWA 1992 Benefit Plan , the Trustees of the UMWA 1993 Benefit Plan and the Trustees of the UMWA Prefunded Benefit Plan		Mountain States Health Alliance dba Russell County Medical Center
UMWA Health and Retirement		Mountain States Managed Care, Inc. (TN Facilities)
United Behavioral Health, Inc.	Commerical & Medicare	Mountain States Health Alliance d/b/a Sycamore Shoals Hospital and Woodridge Psychiatric Hospital
United Behavioral Health, Inc.	TennCare	Mountain States Health Alliance d/b/a Sycamore Shoals Hospital and Woodridge Psychiatric Hospital
United Mine Workers of American, Combined Benefit Fund, UMWA 1992 Benefit Plan, UMWA 1993 Benefit Plan		Blue Ridge Medical Management Corporation
United Payors and United Providers, Inc.		Sycamore Shoals, Quillen, Franklin Woods and KDS
USA Health Network Company, Inc.		JMH
USA Health Network Company, Inc.		JMH Physicians
USA Managed Care Organization, Inc.		Norton Community Hospital
USA Managed Care Organization, Inc.		Smyth County Community Hospital
USA Managed Care Organization, Inc.		Mountain States Health Alliance
USA Managed Care Organization, Inc.		APP
Value Options, Inc.	Commerical	Mountain States Health Alliance dba Woodridge Psychiatric Hospital and Sycamore Shoals

Payor	Product	Mountain States Health Alliance Contracting Party
Value Options, Inc.	TriCare Provider Agreement	Mountain States Health Alliance dba Woodbridge Psychiatric Hospital
Virginia Department of Health	Sterilization Program	Smyth County Community Hospital
Virginia Department of Health, Mount Rogers health district	Virginia Department of Health Office of Purchasing and General Services Standard Contract - Every Women's Life	Johnston Memorial Hospital, Inc.
Virginia Health Network, Inc.		Mountain States Health Alliance & Physicians
Virginia Premier Health Plan, Inc.		ISHN, LLC - Base Agreement (Facilities & Physicians)
Windsor Health Plan, Inc.		Unicoi County Memorial Hospital, Inc. & Nursing Home

Exhibit 13

Mountain States' Currently Planned Fixed Rate Increases

To be submitted pursuant to CID.