(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.

(Continued)

(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.

(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:

		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.

(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

(Continued)

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.

(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

(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.

(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.

(Continued)

(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 investment	—	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 equipment	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.

(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

(Continued)

(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			

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(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.

(Continued)

(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 C

Wellmont EMMA - Annual Disclosures from 2011-2015

*Filed on July 13, 2016 as **Exhibit 34** to the Response #1 to Questions Submitted April 22, 2016 by Tennessee Department of Health*

WELLMONT CFO TO LEAVE HEALTH SYSTEM, SERVE AS TREASURER DURING TRANSITION

KINGSPORT – Beth Ward, who has successfully guided Wellmont Health System's financial strategies as chief financial officer for the past 18 months, will be leaving that post to pursue new professional opportunities.

"Health systems across the country have recently faced significant financial challenges from changing healthcare legislation to a downturn in the national economy," said Denny DeNarvaez, president and CEO of Wellmont. "We are extremely fortunate to have had Beth's leadership and remarkable stewardship of our finances during these times."

The search for a replacement is underway. During the transitional period, Ward will continue serving as Wellmont's treasurer, with the primary responsibilities of overseeing investments, debt management and bank and bondholder relationships.

"Our organization is better because of Beth's service with us, and we look forward to her continued service in this new interim role over the coming months," DeNarvaez said. "We also wish her the very best as she pursues her next career path."

###

Wellmont Health System announces Lee Regional Medical Center closing in wake of healthcare reform; hospital to help patient, co-workers transition

Despite significant efforts by hospital administrators and the local board of directors to secure its future, Lee Regional Medical Center will join the list of hospitals across the country to close in an era of unprecedented changes to health care. Lee Regional Medical Center, located in Pennington Gap, Virginia, represents 2% of Wellmont Health System's operating revenue and this closure will not impact debt service coverage as this is excluded from the calculations under the Wellmont Health System Master Trust Indenture.

Three issues are the primary reasons that have led to this decision – reimbursement cuts associated with the Affordable Care Act, extremely low community use of the hospital and a lack of consistent physician coverage.

Lee Regional will cease all operations on Oct. 1, but patients who need a broad spectrum of care will still have seamless access to other Wellmont Health System facilities in the community and throughout the region. Wellmont Medical Associates will work with other community partners to assess what outpatient services are most needed and how those could be best served in the region.

"We had certainly hoped Lee Regional could remain open as a hospital and continue serving the community, but the difficult realities facing our facility are too much to overcome," said Fred Pelle, the hospital's interim president. "We remain committed to serving the health needs of people who live and work in Lee County and will assist them in whatever way possible in this transition."

The closure is due in part to major cuts in Medicare reimbursements by the federal government associated with the Affordable Care Act and a lack of Medicaid expansion by the commonwealth of Virginia. Another factor is the additional 2 percent cut in Medicare reimbursements enacted because of the federal sequester.

More than 60 percent of the hospital's payments comes from federal and state programs.

Through the American Hospital Association, hospitals across the country agreed to initial cuts in the reimbursements with the understanding Medicaid would be expanded to compensate for that lost revenue. But the U.S. Supreme Court's ruling on the Affordable Care Act left it to the states to decide whether Medicaid should be expanded.

Virginia has put the issue in the hands of a commission consisting of delegates and senators but reached no conclusion. In the interim, the steep cuts have profoundly impacted the financial ability of hospitals in the region and across the country to survive.

"These political decisions clearly can have dire ramifications for small communities and the hospitals that serve them," said Denny DeNarvaez, Wellmont's president and CEO. "For months, Wellmont and other health systems in the region and across the country have outlined the consequences of these cuts on community health. While our local legislators have been

understanding, there is simply not a supportive state or national climate overall to effectively resolve this matter.

“The national goal is to reduce costs and keep people out of the hospital. This is a noble initiative, but the cuts are hitting faster than struggling rural hospitals can respond.”

Another matter that has affected Lee Regional’s ability to continue as a hospital is finding physicians to take call coverage at the hospital.

Pelle said physicians who provided call coverage notified Lee Regional administrators that they would no longer provide this service as of Oct. 1.

“Hospitals rely on physicians from the community for call coverage,” Pelle said. “When that coverage is no longer available, no one can appropriately manage patient care in the hospital. We cannot create the quality or environment of care the community needs and deserves without a reservoir of physician coverage.”

Additional efforts to work with these physicians on a potential solution produced no plan that was sustainable for the hospital and the community, Pelle said.

The hospital has also experienced financial challenges due to a decrease in the number of patients in an economically distressed community obtaining care at the hospital. The hospital made several changes to respond to changing patient needs and reduced revenue, including reducing inpatient and intensive care services.

“Unfortunately, since that time, community usage of the hospital has continued to decline to an average daily census of only a handful of patients,” Pelle said. “Emergency department and outpatient volumes have also fallen during this time. Even though we made appropriate adjustments in our staffing volumes, the financial losses were expected to be $4 million or more per year in the coming years.”

Pelle said Lee Regional is focused on helping co-workers at the hospital obtain new jobs. The hospital employed about 100 people, roughly 1 percent of the county’s workforce, and these co-workers will receive severance pay. Pelle said these co-workers served Lee Regional and the patients they treated with great pride.

Wellmont Medical Associates will also work relentlessly to help patients obtain the care they need. The community assessment that will be undertaken might lead to the development of after-hours clinics, telemedicine consults, testing, imaging, chronic disease management services, and visiting specialty physician clinics.

Primary care services will continue to be available through the Wellmont Medical Associates practices of Drs. Monika Karakattu, Sidney Gilbert and Patrick Molony in Pennington Gap and Jonesville.

Plus, nearby Lonesome Pine Hospital and Holston Valley Medical Center, which serves dozens of people from Lee County every day, are equipped to treat patients from Lee County. These hospitals have also committed to begin new care management efforts for patients transitioning to home health or nursing homes in the county.

WellmontOne Air Transport and Med-Flight II, which have many of the same pieces of equipment used in Wellmont emergency departments, are also ready to assist patients in Lee County with rapid transport. Whether they reach patients via the helipad that will remain available at Lee Regional or at the scene, paramedics and flight nurses on these aircrafts will be available to deliver lifesaving care. The helicopters can reach Holston Valley in 12 minutes and Bristol Regional Medical Center in 18 minutes from Lee Regional.

In addition, Wellmont has instituted a patient navigation and information service to assist residents of the county with any questions related to accessing the services they need. Medical professionals can also be accessed at any time by calling 1-877-230-NURSE (6877) for general medical questions or assistance scheduling testing or hospital services.

“Do not hesitate to access these services and facilities because they are designed help patients and the community during this transition,” Pelle said. “We have had the honor of serving Lee County for many years with high-quality care, and that will continue to be our approach well into the future.”

WELLMONT HEALTH SYSTEM'S BOARD CHAIRMAN, CEO ISSUE STATEMENTS

KINGSPORT – Roger Leonard, chairman of Wellmont Health System's board of directors, issues the following statement:

After four years of strong leadership for our organization, Denny DeNarvaez has decided the time is right for her to leave her role as CEO of Wellmont.

We are experiencing a period of great transformation here at Wellmont as our board continues its process to explore the right and best path to ensure a future that allows us to thrive for generations to come. It is not unusual during these times of transition that there be a change in leadership.

We thank Denny for her contributions to Wellmont during the most pivotal time ever experienced in the health care industry. Under her leadership, Wellmont has accomplished many important strategic objectives, such as:

- Establishing Wellmont Medical Associates, the Wellmont CVA Heart Institute and the Wellmont Cancer Institute as market leaders
- Introducing the Wellmont LiveWell initiative to improve community health and wellness
- Expanding Wellmont's regional access through new physician offices, testing centers and urgent care centers
- Implementing the Epic electronic health record with record pace and best-practice execution
- Adopting the Healing Environment, which advances the patient- and family-centered focus of our care delivery.

She has also established a strong executive leadership team, which remains to capably assist with this transition. We wish her well in her future endeavors.

During this time of transition, the board and Wellmont's executive leadership team will work together until an interim CEO is identified.

The focus of our board continues to be the work of determining the right strategic direction for Wellmont and health care in our region, and we are encouraged by the options before us.

Denny DeNarvaez, president and CEO, issues the following statement.

I am so proud of all that we have accomplished here at Wellmont during my time as CEO. Every day, our physicians and nurses and co-workers serve tirelessly to bring comfort and healing to patients and their families across the region during the most vulnerable of times.

I thank everyone for welcoming me into the Wellmont family for the past four years, and I hope you will understand my need to transition at this time.

###

Bart Hove Named Wellmont's Interim President And CEO, Brings 37 Years of Health Care Leadership Experience

Bart Hove, who provided impressive leadership as president of Bristol Regional Medical Center for 12 years, has been selected as Wellmont Health System's interim president and CEO.

Hove will begin his service Tuesday, Sept. 16, and bring 37 years of experience in health care administration to the helm of Wellmont. He will head the executive leadership team for a diverse health system that has set a standard of excellence for the region in health care delivery. He will work with Wellmont's corporate team and divisional presidents to build on the strengths of all Wellmont hospitals together with Wellmont Medical Associates, the Wellmont Cancer Institute and the Wellmont CVA Heart Institute.

Hove succeeds Denny DeNarvaez, who recently resigned after four years as president and CEO.

"Bart is a remarkable leader who was instrumental in Wellmont's success during his earlier tenure with us," said Roger Leonard, chairman of the health system's board of directors. "He is familiar with Wellmont's operations and has worked hand in hand with our executive leadership team, so he will hit the ground running.

"We are grateful Bart has agreed to assist us during this important time in Wellmont's history and know his wisdom and experience will benefit our organization considerably as we move forward."

Wellmont's board has been engaged for a year and a half in a thorough evaluation of the health system's long-term future in light of the changing national health care landscape. The board has decided to affiliate with another organization and narrowed the list of organizations it is considering to three. The process is in a due diligence phase, with the board possibly deciding on a partner by the end of the year.

"It's an honor for the board to ask me to work with them as we examine Wellmont's options for the future," Hove said. "I have seen the organization's tremendous growth and innovation and witnessed sensational care delivered every day by our outstanding physicians, nurses and other dedicated medical professionals. This will only accelerate as Wellmont takes the next step in its development of the best health care anywhere."

During his time at Bristol Regional, the hospital elevated the quality of care through multiple initiatives. Bristol Regional was designated a Primary Stroke Center and greatly expanded its emergency department and Level II trauma center. The hospital also bolstered its oncology and interventional cardiology programs with new facilities and became the regional leader in robotics with CyberKnife Robotic Radiosurgery System and da Vinci Surgical System. While with Wellmont, Hove was selected as the 2009 recipient of the Tennessee Hospital Association's meritorious service award.

"With the help of so many people, we greatly enhanced the caliber of care through a progressive spirit across Wellmont," Hove said. "Holston Valley Medical Center, our community division hospitals and our

outpatient facilities also found additional ways to remain on the cutting edge of health care. It was a pleasure to be part of a team that was constantly looking for ways to deliver optimal health care for our region."

Prior to joining Wellmont, Hove served as CEO of Delta Regional Medical Center in Greenville, Mississippi; president and CEO of Good Samaritan Hospital in Lexington, Kentucky; CEO of Crestwood Hospital in Huntsville, Alabama; and administrator of Beaches Hospital in Jacksonville, Florida. He was a longtime fellow of the American College of Healthcare Executives.

Hove received a bachelor's degree from the Georgia Institute of Technology in Atlanta and a master's degree in hospital administration from the University of Alabama in Birmingham.

###

FOR IMMEDIATE RELEASE 1/5/10

WELLMONT CEO MIKE SNOW ACCEPTS OPPORTUNITY TO LEAD NATIONAL HOME HEALTH COMPANY

Snow will lead Wellmont through transition period; board to identify interim CEO

KINGSPORT – Mike Snow, who has served as president and CEO of Wellmont Health System since 2008, has been named chief operating officer of Amedisys Inc. (NASDAQ: AMED), a $1.5 billion, publicly traded home health nursing company based in Baton Rouge, La.

Snow will remain at Wellmont through a transition period. With Snow's assistance, the Wellmont board of directors is in the process of identifying an interim CEO and expects to make an appointment by the end of February.

"Mike came to Wellmont to help improve our financial and competitive position, while leading with integrity and vision. He has achieved that mission in spades," said Roger K. Mowen Jr., chairman of the Wellmont board of directors. "We are grateful for his successful efforts to guide Wellmont through a financial review and restatement, update Wellmont's strategic plan and implement improvements that have materially improved annual operating income. Mike has put Wellmont on stronger financial and competitive footing. We wish him the very best in this next chapter of his career."

Snow said he is proud to have worked with Wellmont's employees, physicians and leaders to realize the health system's mission to deliver superior health care with compassion.

"Wellmont is a terrific organization, and I leave knowing I have accomplished what I came here to do – to strengthen the organization operationally and financially and position it for continued success," Snow said. "I am committed to working with the board of directors and leadership team to ensure a smooth transition and will continue to play an active role in identifying an interim CEO to serve as my replacement.

"I will miss all of the talented people at Wellmont but am looking forward to working closer to my family."

Wellmont will continue to operate as usual during this leadership transition. Despite a challenging economy, the health system is performing well and continues to improve.

For the first quarter of the 2010 fiscal year (which ended Sept. 30), income from operations was $9.3 million, or more than 50 percent (or $3.2 million) ahead of the budget of $6.1 million. During the period, surgeries, ER visits and observation volumes were up slightly compared to the prior year's first quarter, while acute discharges decreased slightly.

In August, Standard & Poor's upgraded its outlook on Wellmont to stable, citing the system's "improving financial metrics" and "better-than-expected operating performance." In addition, S&P affirmed Wellmont's BBB+ credit rating.

As previously announced, Beth Ward, a certified public accountant with more than 25 years experience in healthcare finance, will join Wellmont's executive leadership team as chief financial officer this month. Ward will provide assistance with the selection of a new CEO.

"We are fully committed to appointing a CEO of the highest quality to replace Mike," Mowen said. "Our patients, employees, physicians and volunteers deserve an equally qualified and visionary leader."

About Wellmont Health System: Wellmont Health System is a premier provider of healthcare services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive healthcare and wellness services across the region. Wellmont hospitals offer a broad scope of services ranging from community-based acute care to highly specialized tertiary services including two trauma centers.

###

FOR IMMEDIATE RELEASE 2/1/10

WELLMONT NAMES BOB BURGIN INTERIM CEO

KINGSPORT – Bob Burgin, a retired healthcare executive who served for more than two decades as president and CEO of Mission Hospitals in Asheville, N.C., will provide interim leadership for Wellmont Health System as the organization conducts a national search for its next chief executive.

Burgin has been as a member of the Wellmont board of directors since July 2009. He assumes his responsibilities as interim CEO today, working closely with outgoing President and CEO Mike Snow, who will leave the system later this month to become chief operating officer of Amedisys Inc.

"Bob's exemplary record at Mission speaks for itself, and he has demonstrated a keen understanding of the opportunities and challenges facing our hospitals during his tenure on the Wellmont board," said Roger K. Mowen Jr., board chairman. "His experience as a Wellmont board member enables him to hit the ground running, which is a tremendous benefit to our organization and the patients we serve.

"Bob is an experienced leader who will provide strong, steady leadership for our health system during this time of transition."

Burgin served as Mission's president and CEO for nearly 24 years before his retirement in 2004. The organization was repeatedly recognized for its quality of care and efficient operations under his leadership. Following his retirement, he was named Mission's president emeritus. He also worked with Mission's foundation for three years after retirement.

Burgin previously served as chief operating officer of UNC Hospitals' North Carolina Memorial Hospital in Chapel Hill. He was also a captain in the Army Medical Service Corps.

He is a graduate of Miami University in Ohio, where he received a bachelor's degree in history and economics, and the University of Michigan, where he earned a master's degree in health services administration. Burgin has also completed executive programs in health policy and management at Harvard University.

Since his retirement, Burgin has served as a consultant with KPMG in Atlanta and has done extensive consulting for law firms. He has also provided management assistance to an anesthesia management company.

He and his wife have two grown children.

With Burgin's selection as interim CEO, Mowen said, the Wellmont board of directors will now turn its attention to a national search for a permanent president and CEO. The board will work with an executive search firm to identify and select a top candidate, a process expected to be complete within six months.

"As stewards of our communities' hospitals, our board members take this responsibility seriously," Mowen said. "We are committed to a thorough, deliberate search process to identify a leader with both the character and competence to lead our organization in support of our mission to deliver superior health care with compassion."

# # #

FOR IMMEDIATE RELEASE **6/4/10**
CONTACT: Amy Stevens
(423) 230-8235

WELLMONT NAMES ACCOMPLISHED EXECUTIVE MARGARET 'DENNY' DENARVAEZ PRESIDENT AND CEO

KINGSPORT – Margaret "Denny" DeNarvaez, who has provided executive leadership for one of the country's largest faith-based health systems and led a hospital nationally recognized for excellence in cardiac care, has been named president and CEO of Wellmont Health System.

DeNarvaez will assume her new responsibilities Aug. 1, succeeding interim CEO Bob Burgin. She was the unanimous selection of the Wellmont board of directors following a national search process.

"Our search for the right CEO was a thorough, deliberate exercise involving board members, physicians, employees and community leaders," said Roger K. Mowen Jr., chairman of the Wellmont board. "After meeting Denny and seeing firsthand her commitment to excellence and passion for service, every participant in the search process came away with the same strong conviction – this is the right person at the right time for Wellmont Health System, our hospitals and the communities we serve.

"There's a lot of uncertainty in health care these days surrounding healthcare reform, but there's one thing of which I am absolutely certain. With Denny's leadership, our hospitals will build upon our already strong record of clinical and operational excellence. And we'll remain squarely focused on our mission to deliver superior health care with compassion."

DeNarvaez, 54, has more than 27 years' experience in healthcare leadership. She presently serves as CEO of St. John's Mercy Health Care, which includes hospitals in both St. Louis and Washington, Mo. DeNarvaez also provides leadership for Mercy's extensive Missouri and Oklahoma operations, which encompass more than 2,200 licensed beds, nearly 15,000 employees and nearly 3,000 physicians.

As president and CEO of St. John's Mercy Health Care, she oversees the fiscal, strategic

(MORE)

and operational initiatives of multiple facilities, including the 979-bed St. John's Mercy Medical Center. This fully accredited teaching hospital operates St. Louis County's only Level I trauma Center and Level III neonatal intensive care unit.

During her five-year tenure with the Mercy system, DeNarvaez has refocused the organization on its mission, vision and values, led a multimillion-dollar financial turnaround, established a dedicated heart hospital and developed a physician clinical council to leverage the experience and judgment of physicians in operations and planning. Under her leadership, St. John's Mercy has been recognized as a "best place to work" by both the *St. Louis Business Journal* and *Modern Healthcare* magazine.

DeNarvaez previously served as president of Abbott Northwestern Hospital in Minneapolis, part of Allina Hospitals and Clinics. Abbott Northwestern, the largest hospital in Minnesota's Twin Cities, is nationally recognized for clinical expertise in cardiac care through its renowned Minneapolis Heart Institute.

She has also served as CEO and chief financial officer of Florida Medical Center in Fort Lauderdale, Fla.

"It's not often in a person's career you have the opportunity to marry a great job with a great location," DeNarvaez said. "To lead Wellmont Health System, a premier healthcare system, while living in an area we have visited for the past 30 years is a blessing.

"My parents – now both in their 80s – will be within commuting distance. Equally appealing, however, is the opportunity to leverage the great work that has been done to date to make Wellmont a preferred healthcare provider. I feel privileged to have been selected to lead during this chapter in Wellmont's history."

DeNarvaez is a graduate of Drake University in Fort Lauderdale, where she earned a bachelor's degree of business administration in accounting. She is a certified public accountant and holds leadership certifications from the University of Michigan Business School in Ann Arbor and the University of St. Thomas in St. Paul, Minn.

She was the 2009 recipient of the Visionary Leadership Award from the Missouri Hospital Association and in 2007 was named one of the Top 25 most influential businesswomen by the *St. Louis Business Journal*.

About Wellmont Health System: Wellmont Health System is a premier provider of

healthcare services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive healthcare and wellness services across the region. Wellmont hospitals offer a broad scope of services ranging from community-based acute care to highly specialized tertiary services including two trauma centers.

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Wellmont Health System

Denny DeNarvaez

Margaret “Denny” DeNarvaez will become president and CEO of Wellmont Health System Aug. 1. An accomplished executive with nearly 30 years of healthcare experience, DeNarvaez presently serves as CEO of St. John’s Mercy Health Care, which includes hospitals in both St. Louis and Washington, Mo. DeNarvaez also provides leadership for Mercy’s extensive operations in Missouri and Oklahoma, encompassing more than 2,200 licensed beds, nearly 15,000 employees and nearly 3,000 physicians.

During her five-year tenure with the Mercy system, DeNarvaez has refocused the organization on its mission, vision and values, led a multimillion-dollar financial turnaround, established a dedicated heart hospital and developed a physician clinical council to leverage the experience and judgment of physicians in operations and planning. Under her leadership, St. John’s Mercy has been recognized as a “best place to work” by both the St. Louis Business Journal and Modern Healthcare magazine.

DeNarvaez previously served as president of Abbott Northwestern Hospital in Minneapolis, part of Allina Hospitals and Clinics. Abbott Northwestern, the largest hospital in Minnesota’s Twin Cities, is nationally recognized for clinical expertise in cardiac care through its renowned Minneapolis Heart Institute. She has also served as CEO and chief financial officer of Florida Medical Center in Fort Lauderdale, Fla.

DeNarvaez is a graduate of Drake University in Fort Lauderdale, where she earned a bachelor’s degree of business administration in accounting. She is a certified public accountant and holds leadership certifications from the University of Michigan Business School in Ann Arbor and the University of St. Thomas in St. Paul, Minn.

She was the 2009 recipient of the Visionary Leadership Award from the Missouri Hospital Association and in 2007 was named one of the Top 25 most influential businesswomen by the St. Louis Business Journal.

$200,000,000
The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee
Hospital Revenue Bonds
(Wellmont Health System Project),
Series 2006C

CUSIP Numbers: (Base: 865293)
AC8, AD6, AE4, AF1

$55,000,000
Virginia Small Business Financing Authority
Hospital Revenue Bonds
(Wellmont Health System Project),
Series 2007A

CUSIP Numbers: (Base: 928101)
AA2, AB0, AC8

MATERIAL EVENT NOTICE

The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the "TN Issuer") issued the Hospital Revenue Bonds (Wellmont Health System Project), Series 2006C (the "Series 2006C Bonds"), on November 2, 2006 and the Virginia Small Business Financing Authority issued the Hospital Revenue Bonds (Wellmont Health System Project), Series 2007A (the "Series 2007A Bonds") on July 31, 2007, both for the benefit of Wellmont Health System (the "Borrower").

In connection with the issuance of the Series 2006C Bonds and the Series 2007A Bonds, the Borrower undertook to provide each nationally recognized municipal securities information repository certain notice and information regarding certain material events pursuant to Rule 15c2-12 of the Securities Exchange Commission.

In connection with the expected issuance of a revenue and refunding bond by the TN Issuer for the benefit of the Borrower, on September 24, 2014 the Borrower expects to execute and deliver (i) a Master Trust Indenture (the "Amended and Restated Master Indenture") among the Borrower, Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc. and Wellmont Foundation (the "Obligated Group") and U.S. Bank National Association, as master trustee (the "Master Trustee"), to amend and restate the existing Master Trust Indenture dated as of May 1, 1991 (the "Original Master Indenture"), among the Obligated Group and the Master Trustee and (ii) certain amendments (the "Deed of Trust Amendments") to the existing deeds of trust (the "Original Deeds of Trust" and together with the Deed of Trust Amendments, the "Deeds of Trust") securing obligations secured under the Original Master Indenture.

In connection with the issuance of both the Series 2006C Bonds and the Series 2007 Bonds, the Borrower executed and delivered its promissory note for the benefit of the respective bondholders (each a "Note"). Each Note was issued as an "obligation" under the Original Master Indenture.

The Amended and Restated Master Indenture and the Deed of Trust Amendments will (i) modify the rights of holders of all obligations secured under the Original Master Indenture,

including the holders of the Series 2006C Bonds and the Series 2007 Bonds, and (ii) result in a release of certain real property currently subject to the Original Deeds of Trust.

A current draft of the Amended and Restated Master Indenture is on file with the Master Trustee. For a copy please contact Wally Jones, 615.251.0733 or wally.jones@usbank.com.

The Borrower's real and personal property with respect to Wellmont Bristol Regional Medical Center and Wellmont Holston Valley Regional Medical Center will continue to be subject to the Deeds of Trust; however, the Borrower's headquarters building, certain medical office buildings and non-hospital facilities, certain undeveloped land and the two hospitals located in Virginia will no longer be subject to the Deeds of Trust.

Simultaneously with the distribution of this Material Event Notice, the Borrower has caused the distribution of a notice of refunding with respect to the refunding of a portion of the outstanding principal amount of the Hospital Revenue Bonds (Wellmont Health System Project), Series 2006C.

WELLMONT HEALTH SYSTEM

Dated: August 21, 2014

FOR IMMEDIATE RELEASE 8/2/12

ALICE POPE, AN ACCOMPLISHED WELLMONT SENIOR LEADER, NAMED CHIEF FINANCIAL OFFICER

KINGSPORT – Alice Pope, a respected healthcare finance executive and a senior leader at Wellmont Health System for the last three years, has been promoted to chief financial officer.

Pope has most recently served as senior vice president of finance, managed care and revenue cycle. A certified public accountant, she has been entrusted with increasing responsibilities during her 12-year career with Wellmont.

"After a national search, it is very gratifying to find the best candidate within Wellmont to guide our financial operations," said Denny DeNarvaez, president and CEO. "Alice has a proven track record of outstanding financial stewardship, which has benefited Wellmont and the region greatly."

In her service as senior vice president, Pope has been instrumental in enhancing corporate treasury operations and in realizing significant improvements in the system's revenue cycle functions, including managed care contracting and system case management.

Pope has played an essential role in recent physician practice integrations, which have resulted in Wellmont having the largest collective number of pulmonologists, sleep specialists, oncologists and cardiovascular physicians in Northeast Tennessee and Southwest Virginia.

She was also a key figure in the development of the region's first focused network with Cigna, an insurance provider that covers more than 40,000 local lives. Cigna provides health insurance plans for several major employers, including Eastman Chemical Co., and the focused network blended high-quality healthcare services and physicians with reduced costs for employers and employees.

During her tenure in the executive leadership team, Wellmont has consistently improved many of its financial metrics and achieved important benchmarks.

An early highlight in Pope's Wellmont career was her service from 2003-08 as vice president and chief financial officer of Holston Valley Medical Center, Wellmont's largest hospital. She was intimately involved in the development and implementation of Project Platinum, Holston Valley's $114 million expansion and renovation project completed in 2010.

"Alice understands the values of our organization, is committed to its success and possesses the expertise and leadership skills that will ensure Wellmont is fiscally strong well into

the future," DeNarvaez said. "Her integrity and impressive leadership will also serve as excellent models as we further develop successful methods to protect and grow our financial resources."

Pope said she is grateful for the opportunity to take the next step to grow professionally and continue to build Wellmont's reputation in the region.

"Wellmont is well positioned for success amid the changing dynamics of health care," she said. "Although there are many challenges on the horizon, we will use them as steppingstones to achieve an enhanced care model for the communities we are privileged to serve. We have a great team that has helped us remain the region's highest-quality, lowest-cost healthcare provider."

To continue leading the way, Pope said co-workers in Wellmont's financial operations – and everyone else who works for the system – will need to be innovative.

"Our future success depends on our ability to be disciplined, agile and adaptable to thrive in some tough financial realities," she said. "I'm excited to accept this opportunity for an organization I value so much."

Before Pope joined Wellmont, she served as chief financial officer of Baptist Memorial Health Care Corp.'s Mississippi market and as an audit manager with Arthur Andersen.

Pope earned a bachelor's degree in commerce, with a concentration in accounting, from the University of Virginia and a master's in business administration from East Tennessee State University. She is a member of the Healthcare Financial Managers Association, the Tennessee Society of Certified Public Accountants and the Tennessee Hospital Association.

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FOR IMMEDIATE RELEASE 1/9/14

WELLMONT HEALTH SYSTEM LAUNCHES PROCESS TO ASSESS STRATEGIC OPTIONS FOR FUTURE

KINGSPORT—Wellmont Health System officials have launched a process to evaluate strategic options for the organization's future, including the possibility of aligning with another health system.

The Wellmont board of directors and leadership team will spend this year engaged in an exploratory process with healthcare experts to evaluate how Wellmont needs to evolve to thrive in the future.

"Because of the mandate of our vision – to deliver the best healthcare anywhere – we strongly believe we must act now to ensure Wellmont evolves with the rapidly changing healthcare industry and continues to provide outstanding care for generations to come," said Buddy Scott, chairman of Wellmont's board. "While this is just the beginning of a process and we do not have many specifics today, it is important to be as transparent as possible with all the people who matter to this organization."

The current climate of the healthcare industry has resulted in a complex set of challenges for hospitals and health systems nationwide.

These organizations must be prepared for increasing levels of information management and technological innovations, quality mandates, a growing demand for primary care services and population health management to advance the wellness of large groups of patients and reduce their need for inpatient hospital care. Providers are also struggling with low patient volumes, reimbursement cuts and possible performance penalties under the Patient Protection and Affordable Care Act.

The challenges are multiplied in Northeast Tennessee and Southwest Virginia because of extremely low Medicare payment rates and the high volume of Medicaid and uninsured populations. Add to this the recent decisions in Virginia and Tennessee not to expand Medicaid coverage. For Wellmont, all of these factors have made it necessary to improve its financial position by millions of dollars during the next several years. In fiscal 2012, Wellmont had a community benefit of $94 million, which included $77 million in uncompensated care, as well as free programs and services provided to the community, and cash and in-kind donations to community groups.

Due to these challenges, it is becoming increasingly difficult for healthcare organizations to continue to operate as they have in the past without adapting to the new healthcare landscape. As a result, Wellmont is not alone in pursuing a process such as this. Forward-looking health systems nationally are seeking to fully understand their options. In fact, a recent national survey of healthcare leaders found 75 percent of health systems were already pursuing or were considering aligning their organization with another (*HealthLeaders Media*).

"As stewards of a valued community resource, our Board of Directors and leadership team know it is our responsibility to preserve and advance healthcare in our region," said Denny DeNarvaez, CEO of Wellmont Health System. "Unlike many health systems, Wellmont is fortunate to be in a position of clinical strength and relative financial stability thanks to the great work of our physicians, co-workers and leadership. The Board and the administration are committed to continue pursuing all internal options to

ensure the financial stability of our health system for the future. However, by proactively embarking on this process, we are taking our future into our own hands and creating a stronger health system for the communities we serve."

In consultation with national experts, a special committee of the Board has begun a process to assess strategic options for the organization's future. The guiding principles that will govern this assessment are:

- A strong commitment to Wellmont's mission, vision, values and operating philosophy
- Significant financial strength to advance medical, technological and organizational innovation and to develop new care models for the good of the patients and communities it serves
- A contribution to long-term economic development, the advancement of healthcare services and employment opportunities in our region
- A strong vision for the importance of philanthropy, good stewardship of donated funds and community benefit
- Optimization of information and medical technology systems
- A robust physician network and physician recruitment capacity and commitment to physician leadership
- An extensive knowledge and resource base to optimize operational, financial, clinical and purchasing systems

"As we explore potential paths, we have the best interest of our hospitals, physicians, patients and the communities we serve in mind, and we will continue to share information as it becomes available," DeNarvaez said.

"Wellmont is committed to serving patients across Northeast Tennessee and Southwest Virginia and we are motivated by our mission to deliver superior health care with compassion. This will not change with any future direction we consider," Scott said.

About Wellmont Health System

Wellmont Health System is a leading provider of healthcare services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive healthcare and wellness services across the region. Wellmont facilities include Holston Valley Medical Center in Kingsport, Tenn.; Bristol Regional Medical Center in Bristol, Tenn.; Mountain View Regional Medical Center in Norton, Va.; Lonesome Pine Hospital in Big Stone Gap, Va.; Hawkins County Memorial Hospital in Rogersville, Tenn.; and Hancock County Hospital in Sneedville, Tenn. Wellmont is an operating partner with Adventist Health System at Takoma Regional Hospital in Greeneville, Tenn. For more information about Wellmont, please visit www.wellmont.org.

Media advisory: Denny DeNarvaez and Buddy Scott will be available for interviews at 1:30 p.m. EST at Wellmont Corporate offices at 1905 American Way, Kingsport. For those unable to join in person, you may dial 1-800-617-4268 and key pin code 55500382.

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WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE ANNOUNCE PLANS TO PURSUE AN INTEGRATED HEALTH SYSTEM

New organization would make health care more affordable, redirect resources toward improving health of region

KINGSPORT and JOHNSON CITY, Tenn. – (April 2, 2015) – Wellmont Health System and Mountain States Health Alliance have agreed to exclusively explore the creation of a new, integrated and locally governed health system designed to address the serious health issues affecting the region and to be among the best in the nation in terms of quality, affordability and patient satisfaction.

In a term sheet signed Wednesday, the boards of directors of both organizations agree to explore combining the assets and operations of Wellmont and Mountain States into a new health system. This decision follows more than a year of merger discussions, internal analysis within each system, thoughtful conversations in the community and unanimous votes by both boards to examine this option.

"We are excited about this proposed combination that will bring together the capabilities of both Wellmont and Mountain States, combined with a partnership in academics and with our states, to serve the region and result in unprecedented quality and value," said Roger Leonard, chair of Wellmont's board. "We are grateful to the thousands of community and business leaders, physicians, employees and patients who have shared their thoughts throughout this process. It was deliberative and methodical, which led us unanimously to the right conclusion."

"Our board is enthusiastic about this potential partnership," said Barbara Allen, chair of the board for Mountain States. "We and the leadership of Wellmont all care deeply about the region we serve. We share a passion for improving our region's health and our region's economy. We look forward to working closely with the state of Tennessee and the Commonwealth of Virginia, as well as with our payors, to focus on the real drivers of cost reduction and quality-enhancement."

A new board will be created, which will have equal representation from Wellmont and Mountain States, as well as two new independent, jointly appointed members. The board will also include a lead independent director who will be a Wellmont board appointee who will work with the board in coordination with the executive chairman. This is a best practice model frequently used by companies who have an executive chairman.

The president of East Tennessee State University will serve as an ex-officio nonvoting member of the board. The involvement of ETSU will focus on expanding opportunities to compete for research investment in our region, as well as enhancing physician and allied health training for the future.

This new board would direct the proposed health system, which would also have a new name. One leadership team, composed of current executives from both organizations, would lead the combined system. The CEOs of both organizations would share leadership responsibilities.

"Northeast Tennessee and Southwest Virginia disproportionately suffer from serious health issues – cardiovascular disease, diabetes, addiction and access to mental health services, to name a few – and they must be addressed," said Alan Levine, president and CEO of Mountain States, who would become executive chairman and president of the combined system. "The cost of this poor health is not sustainable. By integrating, we can refocus our efforts from being measured based on how many patients we can admit to the hospital and how many ways we can duplicate these efforts, to how we measurably improve the health of our region while eliminating unnecessary costs and making health care more affordable. The people of this region deserve nothing less. We intend to demonstrate the merger's substantial specific potential in these areas."

An integration council with executive and physician leaders from both systems will be formed to further develop plans for a combined system during the next several months. Those plans will be in the best interest of clinical quality and the patients served, will demonstrate shared values and will honor commitments to employees and physicians.

"Together, we'll work alongside our employed and independent physicians to shape the future of health care by modeling effective clinical collaboration, building new community health solutions and becoming a national model for rural health care delivery," said Bart Hove, president and CEO of Wellmont, who would be CEO of the new system. "As one system, our physicians would share best practices, collaborate to benchmark our outcomes against the nation's best and develop new high-level services closer to home."

The systems now enter a due diligence period and will work toward developing a definitive agreement. The definitive agreement will be followed by a process to obtain, among other regulatory requirements, Tennessee and Virginia approvals of the merger, which will likely take through the end of 2015.

In Tennessee, the organizations will pursue approval under the state's COPA (Certificate of Public Advantage) statute. A COPA authorizes the parties to merge and directs the state to actively supervise the new health system to ensure that it continues to benefit the community by providing health care that is affordable, accessible, cost-efficient and high in quality. In Virginia, the health systems will

pursue a process similar to a COPA that is defined by a proposed statute that has been passed by the legislature and awaits the governor's signature.

During the next phases of due diligence, integration analysis, planning for potential integration and government approval, both Mountain States and Wellmont will continue "business as usual" as two separate and independent organizations.

For more information, please visit www.becomingbettertogether.org.

A bondholder conference call will be scheduled in the near future and a notice of this call will be posted on EMMA.

About Wellmont Health System

Wellmont Health System is a leading provider of health care services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive health care, wellness, and long-term care services across the region. Wellmont facilities include Holston Valley Medical Center in Kingsport, Tenn.; Bristol Regional Medical Center in Bristol, Tenn.; Mountain View Regional Medical Center in Norton, Va.; Lonesome Pine Hospital in Big Stone Gap, Va.; Hawkins County Memorial Hospital in Rogersville, Tenn.; and Hancock County Hospital in Sneedville, Tenn. For more information about Wellmont, please visit www.wellmont.org.

About Mountain States Health Alliance

Since 1998, Mountain States Health Alliance has been bringing the nation's best health care close to home to serve the residents of Northeast Tennessee, Southwest Virginia, Southeastern Kentucky and Western North Carolina. This not-for-profit health care organization based in Johnson City, Tenn., operates family of 13 hospitals serving a 29-county region. Mountain States offers a large tertiary hospital with level 1 trauma center, a dedicated children's hospital, several community hospitals, two critical access hospitals, a behavioral health hospital, two long-term care facilities, home care and hospice services, retail pharmacies, a comprehensive medical management corporation, and the region's only provider-owned health insurance company. The team members, physicians and volunteers who make up Mountain States Health Alliance are committed to caring for you and earning your trust. For more information, visit www.mountainstateshealth.com.

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Wellmont Health System and Affiliates

Quarters and Fiscal Years Ended
June 30, 2010 and June 30, 2009

The following financial statements are unaudited and are subject to change upon completion of the annual independent audit.

Wellmont Health System

Management discussion and analysis for the quarter and fiscal year ended June 30, 2010:

The health system's income from operations was $1.6 million for the quarter vs. $9.4 million for the prior year's quarter and $22.8 million for the fiscal year vs. $7.0 million for the prior fiscal year. Excluding unusual items such as real estate gains/losses on sale, write off of disputed contract amounts, and the fiscal 2008 and prior year financial statement restatement costs in fiscal 2009, the normalized amounts would be $2.3 million for the quarter vs. $12.7 million for the prior year's quarter and $26.1 million for the fiscal year vs. $15.7 million for the prior fiscal year.

The annual improvement is a direct result of the operations improvement effort that started in late fiscal 2009. The decrease for the quarter is primarily related to the items discussed in expenses below. Highlights of the quarter and fiscal year operating performance include:

- A large regional cardiology group was acquired in May 2010 and added $6 million of revenue and expenses for the quarter and fiscal year. The following amounts exclude the impact of this acquisition and the unusual items noted above.
- Total revenue increased 0.1% for the quarter and 1.9% for the fiscal year.
- Inpatient volumes were up slightly from prior year, but surgeries were down, especially the higher margin elective surgeries, which is attributable to the general economic conditions in the area.
- Emergency room visits were down from the prior year, which is partly attributable to the economic conditions but also to significant winter weather transportation problems this year.
- Total expenses increased 6.0% for the quarter and 0.6% for the fiscal year. The increase for the quarter is primarily the result of favorable audit adjustments posted in the last quarter of last year, the depreciation and interest on the main portion of Project Platinum which went into service in January 2010, and increased bad debt expense as a result of economic conditions. The slight increase for the fiscal year is primarily the depreciation and interest on Project Platinum and increased bad debt expense, mostly offset by reduced salaries and benefits from improved labor productivity.
- Hospital labor productivity improved 5.5% for the fiscal year and was flat for the quarter.

The health system's balance sheet and bond covenants highlights include:

- Days cash on hand increased from 133 days at June 30, 2009 to 172 days at March 31, 2010 but decreased slightly to 170 days at June 30, 2010. The small quarterly decrease was driven by $19 million of EBITDA being exceeded by $10 million of decreased investment portfolio performance/value, $6 million of interest, and $8 million of non-bond capital expenditures. The fiscal year increase was driven by $87 million of EBITDA and $23 million of improved investment portfolio performance/value, offset by $20 million of interest and $14 million of non-bond capital expenditures. The 170 days is well above the requirement of 100 days.
- Unrestricted net assets decreased by $14.4 million for the quarter and increased by $38.6 million for the fiscal year. The quarterly decrease was primarily driven by $10.4 million of decreased investment portfolio performance/value, $3.4 million of swap valuation adjustments and $1.9 million of pension plan adjustments, partially offset by $1.6 million of income from operations. The fiscal year increase was driven by $22.8 million income from operations and $23.3 million of improved investment portfolio performance/value, partially offset by $2.7 million of swap valuation adjustments and $3.5 million of pension adjustments.
- Debt service coverage increased from 1.56 at June 30, 2009 to 2.64 at March 31, 2010 but decreased to 2.08 at June 30, 2010. The quarterly decrease was primarily due to a decrease in EBITDA of $7.0 million, an increase in investment losses of $5.3 million (due to an impairment of equity investments of $8.2 million), and a negative $3.4 million swap valuation adjustment vs. a positive $6.6 million in the prior year. The fiscal year increase was primarily due to an increase in EBITDA of $20.6 million less the net negative $0.9 million change in investment income, swap valuation adjustments, and discontinued operations. The 2.08 is well above the requirements of 1.10 and 1.25.

In June 2010, the health system entered into a definitive agreement to sell its Medical Mall Pharmacy retail pharmacy operations. The losses for Medical Mall Pharmacy and Jenkins Community Hospital (sold in April 2009) are now included in discontinued operations for all periods presented.

Wellmont Health System

The following table shows a comparison of the total volumes for acute discharges, observation patients, surgeries and emergency room visits for the quarters and fiscal years ended June 30, 2010 and June 30, 2009. Note that Jenkins Community Hospital was acquired as of July 16, 2007, but closed and sold as of April 30, 2009, so its volumes are not included.

	FY10 QTR 4	FY09 QTR 4	FY10 YTD	FY09 YTD
Hospitals	7	7	7	7
Acute Discharges	10,347	10,270	41,380	42,558
Observation Patients	2,407	2,286	9,530	8,092
Total In/Observation Patients	12,754	12,556	50,910	50,650
Surgeries	6,143	6,394	23,938	25,128
Emergency Room Visits	54,413	56,415	218,007	222,560

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2010 and June 30, 2009
(Dollars in Thousands)(Unaudited)

	6/30/10	6/30/09
Assets		
Current assets:		
Cash and cash equivalents	$ 35,711	$ 62,791
Assets limited to use that are required for current liabilities	0	2,201
Patient accounts receivable	94,057	98,071
Other receivables	10,919	11,173
Inventories	18,294	17,169
Prepaid expenses & other current assets	7,002	6,040
Total current assets	165,983	197,445
Assets limited as to use, net of current portion	301,807	245,601
Land, buildings and equipment, net	450,205	442,611
Other assets:		
Long-term investments	32,391	30,072
Investments in affiliates	32,019	31,977
Deferred debt expense, net	4,644	4,824
Goodwill, net	9,501	9,508
Other	731	797
	79,286	77,178
Total assets	$ 997,281	$ 962,835
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	10,143	13,198
Lines of credit / notes payable	14,000	15,811
Accounts payable and accrued expenses	74,679	77,139
Estimated third-party payor settlements	11,672	12,441
Current portion of other long-term liabilities	7,251	6,352
Total current liabilities	117,745	124,941
Long-term debt, less current portion	467,833	474,608
Other long-term liabilities, less current portion	47,364	38,422
Total liabilities	632,942	637,971
Net assets:		
Unrestricted	358,620	320,030
Temporarily restricted	4,551	3,589
Permanently restricted	1,168	1,245
Total net assets	364,339	324,864
Total liabilities and net assets	$ 997,281	$ 962,835

Wellmont Health System and Affiliates
Consolidated Statement of Operations and Change in Net Assets
The quarters and fiscal years ended June 30, 2010 and June 30, 2009
(Dollars in Thousands)(Unaudited)

	FY10 QTR 4	FY09 QTR 4	FY10 YTD	FY09 YTD
Revenue:				
Net patient revenue	183,178	178,393	715,057	699,303
Other revenue	8,028	7,478	31,472	27,842
Total revenue	191,206	185,871	746,529	727,145
Expenses:				
Salaries and benefits	82,497	77,827	310,667	323,801
Medical supplies and drugs	38,197	35,347	150,143	141,044
Purchased services	20,225	21,005	74,922	81,031
Interest	5,675	4,548	20,110	16,013
Provision for bad debts	13,167	12,126	57,431	52,649
Depreciation and amortization	11,512	11,783	43,711	42,957
Other	18,335	13,819	66,735	62,603
Total expenses	189,608	176,455	723,719	720,098
Income from operations	$1,598	$9,416	$22,810	$7,047
Nonoperating gains (losses):				
Investment income	(8,907)	(3,557)	(1,827)	4,181
Derivative valuation adjustments	(3,402)	6,562	(2,693)	(5,747)
Other, net	(1,060)	(247)	(1,870)	(625)
Nonoperating (losses) gains, net	(13,369)	2,758	(6,390)	(2,191)
Revenues and gains in excess of expenses and losses before discontinued operations	($11,771)	$12,174	$16,420	$4,856
Discontinued operations	(1)	(2,317)	(1,109)	(4,456)
Revenues and gains in excess of expenses and losses	($11,772)	$9,857	$15,311	$400
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	(1,452)	26,136	25,151	(60,663)
Net assets released from restrictions for additions to land, buildings, and equipment	750	1,102	1,556	2,758
Transfer to/from permanently restricted net assets	0	0	79	0
Change in the funded status of benefit plans and other	(1,912)	(13,068)	(3,507)	(13,568)
Increase (decrease) in unrestricted net assets	(14,386)	24,027	38,590	(71,073)
Changes in temporarily restricted net assets:				
Contributions	1,189	(1)	2,934	1,944
Net assets released from temporary restrictions	(1,337)	(1,209)	(1,972)	(3,154)
Increase (decrease) in temporarily restricted net assets	(148)	(1,210)	962	(1,210)
Changes in permanently restricted net assets:				
Transfer to/from unrestricted net assets	0	0	(79)	0
Permanently restricted contributions and investment income	0	0	2	645
Increase (decrease) in permanently restricted net assets	0	0	(77)	645
Change in net assets	(14,534)	22,817	39,475	(71,638)
Net assets, beginning of period	378,873	302,048	324,864	396,501
Net assets, end of period	364,339	324,864	364,339	324,863

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2010 and June 30, 2009
(Dollars in Thousands)(Unaudited)

	FY10 YTD	FY09 YTD
Cash flows from operating activities:		
Change in net assets	$ 39,475	$ (71,638)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	43,711	42,988
Net realized and unrealized (gains) losses on investments	(25,151)	60,663
Unrealized (gain) loss on swaps	2,693	(5,747)
(Gain) loss on sale of fixed assets	1,282	660
Increase (decrease) in cash due to changes in:		
Accounts receivable	4,014	11,444
Inventories	(1,125)	(353)
Prepaid expenses and other current assets	(708)	1,508
Accounts payable and accrued expenses	11,831	41,056
Net (increase) decrease in other assets	(76,244)	(907)
Net cash provided by operating activities	(222)	79,674
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(52,588)	(80,043)
Transfer to/from bond funds	38,575	55,207
Net cash used in investing activities	(14,013)	(24,836)
Cash flows from financing activities:		
Proceeds from note payable	14,000	0
Repayment of line of credit	(14,000)	0
Repayment of long term debt	(12,845)	(7,736)
Net cash used in financing activities	(12,845)	(7,736)
Increase (decrease) in cash and cash equivalents	(27,080)	47,102
Cash and cash equivalents, beginning	62,791	15,689
Cash and cash equivalents, ending	$ 35,711	$ 62,791

Wellmont Health System and Affiliates

Consolidated Balance Sheets as of
June 30, 2011 and June 30, 2010

Consolidated Statements of Operations and Changes in Net Assets and Statements of Cash Flows for the Quarters and Fiscal Years ended
June 30, 2011 and June 30, 2010

The following financial statements are unaudited and are subject to change upon completion of the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2011

Volumes:

Volumes were generally up from the same quarter last year. Inpatient and observation volumes grew by 865 patients or 6.8% over the same quarter last year, with inpatients up 1.0% and observation patients up more than 30%, primarily due to a change in post-surgical patient classification and partially due to continued managed care payor changes. Emergency room visits were 0.7% over the same quarter last year. Other outpatient volume was 5.7% over the same quarter last year. Surgical volumes were down 3.7% from the same quarter last year in both the inpatient and outpatient settings. Deliveries were down 12.1% due to obstetrician turnover at Holston Valley Medical Center and Lonesome Pine Hospital. Our physician office visits were up 9.3% primarily due to the acquisitions of a large cardiology practice in May 2010 and a pulmonology practice in January 2011.

Comparing the last fiscal year to the current fiscal year, we experienced a positive 3.9% growth in our inpatient and observation volumes. Our emergency room visits are lagging last year by 1.9% primarily due to utilization trends. Other outpatient volumes were 3.0% over last year. We had surgical growth of 2.3% entirely due to outpatient volumes. Deliveries were down 8.1% due to obstetrician turnover at Holston Valley Medical Center and Lonesome Pine Hospital. Physician office visits were up 20.4% primarily due to the acquisitions noted above.

Length of stay for the quarter and year-to-date is trending slightly higher as a result of moving the shorter length of stay cases to the outpatient arena. Our case mix indices are trending slightly lower than last year as a result of the mix between medical and surgical cases.

Statement of Operations:

The changes that follow exclude the impact of the acquisitions of the cardiology practice in May 2010 and the pulmonology practice in January 2011, and the TennCare fee assessment which was new for fiscal 2011. In total, these items added $9.8 million of net patient revenue, $0.8 million of other revenue, and $11.1 million of expenses for the quarter over the prior year and $51.3 million of net patient revenue, $4.2 million of other revenue, and $58.5 million of expenses for the fiscal year over the prior year.

Quarter ended June 30, 2011 versus quarter ended June 30, 2010:

Net patient revenue has grown $10.1 million and bad debt expense increased $3.7 million over the same quarter last year, so the net change of these two lines is an increase of $6.4 million or 3.9% (the classification of bad debt and charity was refined considerably in the last quarter of fiscal 2011). Other revenue decreased as a result of lower performance related to the Takoma and imaging joint ventures.

Salaries and benefits have increased by $0.7 million or 0.9% driven primarily by the higher volumes. Supplies have increased by $0.7 million or 1.8% driven by the higher volumes and higher drug costs, particularly in oncology. Interest decreased $0.9 million due to the reduction

in notes payable and letter of credit fees. Other expenses decreased $1.0 million as the prior year included acquisition and other one time expenses.

Fiscal 2011 versus fiscal 2010:

Net patient revenue has grown $23.2 million and bad debt expense increased $1.8 million over the prior fiscal year, so the net change of these two lines is an increase of $21.4 million or 3.3%. Other revenue decreased as a result of lower performance related to the Takoma, imaging and lab joint ventures.

Salaries and benefits has increased by $6.2 million or 2.0% driven by the higher volumes, an increase in FTEs for patient care as well as to support computerized order entry and electronic health record system build and implementation. Supplies have increased by $8.3 million or 5.5% driven by the higher volumes and higher drug costs, particularly in oncology. Purchased services increased by $3.5 million as a result of physician fees at the hospitals, a new urgent care operation, and physician practice management and system implementation costs. Interest and depreciation increases are related to the completion of Project Platinum.

For the fiscal year, growth in expenses has out-stripped the growth in revenues resulting in a 2.2% operating margin versus 3.2% for the prior fiscal year. However, the strong volume in the last quarter produced an operating margin of 3.4% which was more than the prior year's last quarter of 0.9%.

Investments are performing well with the rebound in the market while the mark-to-market on our derivatives is not as volatile as last year, both for the quarter and fiscal year.

Balance Sheet:

In May 2011, the Series 2006A bonds (par $76,595,000) were refunded with the Series 2011 bonds (par $76,165,000). The total return swap associated with the Series 2006A bonds was terminated and a new total return swap associated with the Series 2011 bonds was initiated with a different counterparty. Also in May 2011, the letter of credit provider on the Series 2005 bonds was replaced with a different letter of credit provider. In November 2010, a $30 million bank qualified loan was issued with a cumulative drawdown of $15 million at June 30, 2011. This partially offset the use of $13 million in the first quarter to pay off the taxable bond issue. $7 million of the short term note payable was repaid in January 2011 and the remaining $7 million was repaid in June 2011. The purchase of the pulmonary practice that operated a free standing ambulatory surgery center and two sleep laboratories resulted in the increase in goodwill. Net patient receivables grew as a result of our physician practice acquisitions and billing system conversion. Our debt to capitalization position and debt service coverage have both improved for the quarter and fiscal year. Days cash on hand has increased for the quarter and decreased slightly for the fiscal year due to the acquisitions and debt changes.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics of the inpatient and specialty care facilities owned and operated by Wellmont for the quarters and twelve months ended June 30, 2011 and June 30, 2010.

	FY11 QTR 4	FY10 QTR 4	FY11 YTD	FY10 YTD
Hospital Statistics:				
Beds in Service	781	781	781	781
Acute Discharges	10,450	10,347	42,070	41,380
Observation Patients	3,169	2,407	10,841	9,530
Patients in Bed	13,619	12,754	52,911	50,910
Patient Days	45,260	43,505	183,934	177,715
Average Length of Stay (Days)	4.33	4.20	4.37	4.29
Daily Census including Observations	532	505	534	513
Percent Occupancy	68.14%	64.60%	68.33%	65.69%
Emergency Room Visits	53,144	52,761	208,252	212,383
Outpatient Registrations excluding ER	58,227	55,111	225,035	218,400
Deliveries	494	562	2,056	2,238
Surgical Cases:				
Inpatient	2,431	2,579	10,054	10,372
Outpatient	6,436	6,631	26,284	25,160
Physician Office Visits:	79,313	72,585	310,896	258,263

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2011 and June 30, 2010

	FY11 YTD	FY10 YTD
Medicare	32.7%	32.5%
Medicare Managed Care	19.8%	18.4%
Medicaid	12.8%	13.5%
Managed Care	25.1%	25.0%
Self	6.5%	6.5%
Other	3.1%	4.1%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2011 and June 30, 2010
(Dollars in Thousands)(Unaudited)

	As of 6/30/11	As of 6/30/10
Assets		
Current assets:		
Cash and cash equivalents	$ 36,558	$ 35,711
Assets limited to use that are required for current liabilities	1,903	1,815
Patient accounts receivable	108,565	94,057
Other receivables	9,904	10,919
Inventories	17,830	18,294
Prepaid expenses & other current assets	7,162	7,003
Total current assets	181,922	167,799
Assets limited as to use, net of current portion	319,387	301,807
Land, buildings and equipment, net	447,634	450,205
Other assets:		
Long-term investments	36,437	32,391
Investments in affiliates	31,177	32,019
Deferred debt expense, net	5,847	4,644
Goodwill, net	16,721	9,501
Other	1,875	730
	92,057	79,285
Total assets	$ 1,041,000	$ 999,096
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	9,262	11,958
Short term notes payable	0	14,000
Accounts payable and accrued expenses	68,952	74,679
Estimated third-party payor settlements	16,533	11,672
Current portion of other long-term liabilities	8,527	7,251
Total current liabilities	103,274	119,560
Long-term debt, less current portion	453,958	467,833
Other long-term liabilities, less current portion (1)	42,006	44,977
Total liabilities	599,238	632,370
Net assets:		
Unrestricted	434,662	358,620
Temporarily restricted	3,570	4,551
Permanently restricted	1,174	1,168
Noncontrolling interests (1)	2,356	2,387
Total net assets	441,762	366,726
Commitments and contingencies		
Total liabilities and net assets	$ 1,041,000	$ 999,096

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

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2011 and June 30, 2010
(Dollars in Thousands)(Unaudited)

	FY11 QTR 4	FY10 QTR 4	FY11 YTD	FY10 YTD
Revenue:				
Net patient revenue	$197,557	$177,644	$767,450	$692,920
Other revenue	7,002	7,423	29,799	29,237
Total revenue	204,559	185,067	797,249	722,157
Expenses:				
Salaries and benefits	88,283	82,498	347,185	310,667
Medical supplies and drugs	39,289	38,197	160,565	150,143
Purchased services	20,547	20,226	80,348	74,922
Interest	4,805	5,674	20,750	20,110
Provision for bad debts	11,372	7,632	37,858	35,293
Depreciation and amortization	11,392	11,512	46,059	43,711
Other	21,946	17,730	87,319	64,499
Total expenses	197,634	183,469	780,084	699,345
Income from operations	6,925	1,598	17,165	22,812
Nonoperating gains (losses)(1):				
Investment income	2,059	(6,068)	10,383	1,012
Derivative valuation adjustments	(1,595)	(3,401)	1,355	(2,693)
Gain on bond dissolution	1,041	0	1,041	0
Other, net	0	(809)	(610)	(805)
Nonoperating (losses) gains, net	1,505	(10,278)	12,169	(2,486)
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	8,430	(8,680)	29,334	20,326
Discontinued operations	82	(1)	44	(1,109)
Revenues and gains in excess of expenses and losses	$8,512	($8,681)	$29,378	$19,217
Income attributable to noncontrolling interests (1)	(225)	(271)	(1,238)	(1,065)
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	8,287	(8,952)	28,140	18,152
Other changes in unrestricted net assets (1):				
Change in net unrealized gains (losses) on investments	2,214	(4,291)	42,186	22,312
Net assets released from restrictions for additions to land, building and equipment	1,563	750	2,852	1,555
Transfer to/from Temporarily restricted net assets	(18)	0	(18)	0
Transfer to/from permanently restricted net assets	0	0	0	79
Change in the funded status of benefit plans and other	2,777	(1,914)	2,882	(3,508)
Increase (decrease) in unrestricted net assets	14,823	(14,407)	76,042	38,590
Changes in temporarily restricted net assets:				
Contributions	419	1,189	2,549	2,934
Transfer to/from unrestricted net assets	18	0	18	0
Net assets released from temporary restrictions	(1,684)	(1,337)	(3,548)	(1,972)
Increase (decrease) in temporarily restricted net assets	(1,247)	(148)	(981)	962
Changes in permanently restricted net assets:				
Transfer to/from unrestricted net assets	0	0	0	(79)
Permanently restricted contributions and investment income	4	0	6	2
Increase (decrease) in permanently restricted net assets	4	0	6	(77)
Changes in noncontrolling interests (1):				
Income attributable to noncontrolling interests	225	271	1,238	1,065
Distributions to noncontrolling interests	(154)	0	(1,178)	(711)
Changes in noncontrolling percentages	0	0	(91)	(21)
Increase (decrease) in noncontrolling interests	71	271	(31)	333
Change in net assets (1)	13,651	(14,284)	75,036	39,808
Net assets, beginning of period (1)	428,111	381,010	366,726	326,918
Net assets, end of period (1)	$441,762	$366,726	$441,762	$366,726

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

Certain 2010 amounts have been reclassified to conform to the 2011 presentation.

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2011 and June 30, 2010
(Dollars in Thousands)(Unaudited)

	FY11	FY10
Cash flows from operating activities:		
Change in net assets (1)	$ 75,036	$ 39,808
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	46,059	43,711
Net realized and unrealized (gains) losses on investments	(52,569)	(23,324)
Derivative valuation adjustments	(1,355)	2,693
Gain on bond dissolution	(1,041)	0
(Gain) loss on sale of fixed assets	(162)	1,282
Increase (decrease) in cash due to changes in:		
Accounts Receivable	(14,508)	4,014
Inventories	464	(1,125)
Prepaid expenses and other current assets	854	(708)
Accounts payable and accrued expenses	(1,774)	11,831
Net decrease (increase) in other assets (1)	(4,990)	(2,531)
Net cash provided by operating activities	46,014	75,651
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(43,326)	(51,327)
Transfer to/from Bond Funds	8,332	38,575
Transfer to/from Board Designated Funds	26,884	(71,773)
Acquisitions	(7,056)	(2,421)
Net cash used in investing activities	(15,166)	(86,946)
Cash flows from financing activities:		
Proceeds from long term debt	91,133	0
Proceeds from note payable	0	14,000
Repayment of line of credit	0	(15,800)
Repayment of note payable	(14,000)	0
Repayment of long term debt	(107,135)	(12,083)
Net cash used in financing activities	(30,002)	(13,883)
Increase (decrease) in cash and cash equivalents	846	(25,178)
Cash and cash equivalents, beginning	35,711	60,889
Cash and cash equivalents, ending	$ 36,558	$ 35,711

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

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

		6/30/11	6/30/10
Capitalization			
Current portion of long-term debt		$ 9,262	$ 11,958
Short-term notes payable		-	14,000
Long-term debt, less current portion	A	453,958	467,833
Total debt		463,220	493,791
Unrestricted net assets	B	434,662	358,620
Other net assets		7,100	8,106
Total net assets		441,762	366,726
Long-term debt plus Unrestricted net assets	A+B	$888,620	$826,453
Long-term debt to Capitalization	A/(A+B)	0.511	0.566
Debt Service Coverage			
Revenue and gains in excess of expenses and losses (12 months)		$ 29,378	$ 19,217
Add back:			
Depreciation and amortization (12 months)		46,059	43,711
Interest expense (12 months)		20,750	20,110
(Gain) Loss from discontinued operations (12 months)		(44)	1,109
Total income available for debt service per Master Trust Indenture	C	96,143	84,147
Maximum annual debt service	D	$ 35,157	$ 38,050
Debt Service Coverage Ratio per Master Trust Indenture	C/D	2.73	2.21
Days Cash on Hand			
Unrestricted cash		$ 36,558	$ 35,711
Unrestricted investments:			
Capital improvements		273,886	247,674
Long-term investments		36,437	32,391
Less illiquid investments		(38,349)	(35,003)
	E	308,532	280,773
Operating expenses (12 months)		780,084	699,345
Less depreciation and amortization		(46,059)	(43,711)
Total cash expenses		734,025	655,634
Number of days in the period		365	365
Daily cash operating expenses	F	$ 2,011	$ 1,796
Days cash on hand	E/F	153.42	156.31

Wellmont Health System and Affiliates

Consolidated Balance Sheets as of
June 30, 2012 and June 30, 2011

Consolidated Statements of Operations and Changes in Net Assets
for the Quarters and Fiscal Years ended
June 30, 2012 and June 30, 2011

The following financial statements are unaudited but agree to
the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2012

Volumes:

Volumes were mixed compared to the same quarter last year. Inpatients were down 6.3% and observation patients were up 5.5%, due to continued managed care payor changes. Emergency room visits were down 3.6% and other outpatient volume was up 2.3%. Surgical volumes were up 4.2% and deliveries were up 6.7%. Our physician office visits were up 20.1% primarily due to the acquisitions of a cardiology practice in October 2011 and a multispecialty practice in January 2012.

Volumes were also mixed compared to the prior fiscal year. Inpatients were down 4.6% and observation patients were up 26.1%, due to a change in post-surgical patient classification and to continued managed care payor changes. Emergency room visits were the same as last year and other hospital outpatient volumes were up 5.1%. Surgical volumes were the same as last year and deliveries were down 1.7%. Physician office visits were up 15.9% primarily due to the acquisitions noted above.

Length of stay for the quarter and year-to-date is trending slightly lower due to a focus on case management. The case mix indices are the same as last year.

Statement of Operations:

We adopted Accounting Standards Update 2011-07 regarding the presentation of patient service revenue and bad debts this fiscal year on a retroactive basis. There is no impact on income from operations and simply moves the provision for bad debts from expenses to revenue.

Quarter ended June 30, 2012 versus quarter ended June 30, 2011:

Net patient service revenue increased $2.3 million or 1.2% from the same quarter last year. Other revenue increased $14.4 million primarily as a result of $12.8 million of Electronic Health Record Meaningful Use amounts earned during the quarter by Wellmont Health System hospitals and physician practices and $1.4 million earned by Takoma Regional Hospital (of which Wellmont Health System owns 60% so recorded $0.8 million)(also see the fiscal year discussion below).

Salaries and benefits increased $8.3 million or 9.5%, driven by the physician practice growth and acquisitions. Hospital productivity improved, as hours per adjusted discharge decreased 1.7%. Supplies increased $1.7 million or 4.4% primarily due to growth in infusion volumes, particularly in oncology.

Income from operations of $11.6 million exceeded the $6.9 million for the same quarter last year, primarily due to the Meaningful Use amounts.

Fiscal 2012 versus fiscal 2011:

Net patient revenue increased $12.2 million or 1.7% over the prior fiscal year. Other revenue increased $18.1 million primarily as a result of the Electronic Health Record Meaningful Use amounts earned during the year, with $13.1 million earned by Wellmont Health System hospitals and physician practices and $3.2 million earned by Takoma Regional Hospital (of which Wellmont Health System owns 60% so recorded $1.9 million). However, significant costs have been incurred to purchase and implement the systems necessary to achieve Meaningful Use. This includes approximately $13 million of capital costs which resulted in approximately $5 million of annual depreciation and maintenance costs plus $4.6 million of staff costs to implement the systems.

Salaries and benefits increased $21.6 million or 6.2% primarily due to the physician practice acquisitions ($9.5 million) and the $4.6 million to implement the systems. Hospital productivity improved, as hours per adjusted discharge decreased 6.7%. Supplies increased $3.8 million or 2.4% primarily due to growth in infusion volumes, particularly in oncology.

Income from operations of $22.3 million exceeded the prior fiscal year of $17.2 million. Net income (shown as “Revenues and gains in excess of expenses and losses attributable to Wellmont Health System”) of $32.9 million exceeded the prior fiscal year of $28.2 million.

Balance Sheet:

Days cash on hand increased as a result of the strong operating performance and investment returns. Net patient accounts receivable increased primarily as a result of the physician practice acquisitions. Other receivables increased due to the accrual of the Meaningful Use amounts earned at June 30, 2012. Accounts payable and accrued expenses increased primarily due to having a pay period end on June 30, 2012. Net assets was negatively impacted by an increase in pension liabilities as a result of the continued low interest rate environment. Debt to capitalization and debt service coverage ratios both improved as a result of the strong operating performance.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics of the inpatient and specialty care facilities owned and operated by Wellmont for the quarters and fiscal years ended June 30, 2012 and June 30, 2011.

	FY12 QTR 4	FY11 QTR 4	FY12 YTD	FY11 YTD
Hospital Statistics:				
Acute Discharges	9,790	10,450	40,121	42,070
Observation Patients	3,344	3,169	13,669	10,841
Patients in Bed	13,134	13,619	53,790	52,911
Patient Days	41,495	45,260	173,533	183,934
Average Length of Stay (Days)	4.24	4.33	4.33	4.37
Daily Census including Observations	493	532	511	532
Emergency Room Visits	51,216	53,144	208,013	208,252
Outpatient Registrations excluding ER	59,575	58,227	236,437	225,035
Deliveries	527	494	2,021	2,056
Surgical Cases:				
Inpatient	2,401	2,431	9,418	10,054
Outpatient	6,840	6,436	26,839	26,284
Total Surgical Cases	9,241	8,867	36,257	36,338
Physician Office Visits	95,271	79,313	359,942	310,578

The following table shows the percentage of gross patient service revenue by payor for the fiscal year ended June 30, 2012 and the fiscal year ended June 30, 2011.

	FY12 All Year	FY11 All Year
Medicare	32.1%	32.7%
Medicare Managed Care	20.8%	19.8%
Medicaid	11.4%	12.7%
Managed Care	25.3%	25.2%
Self	7.7%	6.5%
Other	2.7%	3.1%
	100.0%	100.0%

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Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2012 and June 30, 2011
(Dollars in Thousands)(Unaudited)

	As of 6/30/12	As of 6/30/11
Assets		
Current assets:		
Cash and cash equivalents	$ 44,930	$ 36,558
Assets limited to use that are required for current liabilities	4,372	1,902
Patient accounts receivable	108,265	101,565
Other receivables	23,805	9,904
Inventories	17,862	17,830
Prepaid expenses & other current assets	7,462	7,163
Total current assets	206,696	174,922
Assets limited as to use, net of current portion	339,030	319,387
Land, buildings and equipment, net	458,048	454,937
Other assets:		
Long-term investments	36,633	36,437
Investments in affiliates	32,646	31,177
Deferred debt expense, net	5,419	5,847
Goodwill, net	17,090	16,721
Other	651	1,875
	92,439	92,057
Total assets	$ 1,096,213	$ 1,041,303
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ 11,913	$ 9,273
Accounts payable and accrued expenses	81,243	70,943
Estimated third-party payor settlements	15,535	9,533
Current portion of other long-term liabilities	5,782	8,527
Total current liabilities	114,473	98,276
Long-term debt, less current portion	459,654	458,882
Other long-term liabilities, less current portion	54,060	42,384
Total liabilities	628,187	599,542
Net assets:		
Unrestricted	458,218	434,661
Temporarily restricted	5,739	3,570
Permanently restricted	1,304	1,174
Noncontrolling interests	2,765	2,356
Total net assets	468,026	441,761
Commitments and contingencies		
Total liabilities and net assets	$ 1,096,213	$ 1,041,303

Certain FY2011 amounts have been reclassified to conform to the FY2012 presentation.

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2012 and June 30, 2011
(Dollars in Thousands)(Unaudited)

	FY12 QTR 4	FY11 QTR 4	FY12 YTD	FY11 YTD
Revenue:				
Patient service revenue (net of contractual allowances and discounts)	$209,950	$197,557	$813,229	767,450
Provision for bad debts	(21,462)	(11,372)	(71,407)	(37,858)
Net patient service revenue less provision for bad debts	188,488	186,185	741,822	729,592
Other revenue	21,352	7,002	47,904	29,799
Total revenue	209,840	193,187	789,726	759,391
Expenses:				
Salaries and benefits	96,632	88,283	368,772	347,185
Medical supplies and drugs	41,017	39,289	164,397	160,565
Purchased services	21,128	20,547	79,509	80,348
Interest	5,428	4,805	21,677	20,750
Depreciation and amortization	12,290	11,392	46,403	46,059
Other	21,777	21,946	86,645	87,319
Total expenses	198,272	186,262	767,403	742,226
Income from operations	11,568	6,925	22,323	17,165
Nonoperating gains (losses):				
Investment income	6,631	2,058	17,272	10,383
Derivative valuation adjustments	5,305	(1,594)	1,807	1,355
Gain on bond dissolution	0	1,042	0	1,042
Other, net	0	0	0	(519)
Nonoperating gains (losses), net	11,936	1,506	19,079	12,261
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	23,504	8,431	41,402	29,426
Discontinued operations	92	82	88	44
Revenues and gains in excess of expenses and losses	23,596	8,513	41,490	29,470
Income attributable to noncontrolling interests	(504)	(225)	(1,670)	(1,238)
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	23,092	8,288	39,820	28,232
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	(9,042)	2,214	(9,534)	42,186
Net assets released from restrictions for additions to land, buildings, and equipment	2,801	1,563	3,766	2,852
Transfer to/from Temporarily restricted net assets	0	(18)	0	(18)
Change in the funded status of benefit plans and other	(10,495)	2,776	(10,495)	2,789
Increase (decrease) in unrestricted net assets	6,356	14,823	23,557	76,041
Changes in temporarily restricted net assets:				
Contributions	431	419	6,661	2,548
Transfer to/from unrestricted net assets	0	18	0	18
Net assets released from temporary restrictions	(2,988)	(1,684)	(4,492)	(3,547)
Increase (decrease) in temporarily restricted net assets	(2,557)	(1,247)	2,169	(981)
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	128	4	130	6
Increase (decrease) in permanently restricted net assets	128	4	130	6
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	504	225	1,670	1,238
Distributions to noncontrolling interests	(369)	(155)	(1,261)	(1,178)
Changes in noncontrolling percentages				(92)
Increase (decrease) in noncontrolling interests	135	70	409	(32)
Change in net assets	4,062	13,650	26,265	75,034
Net assets, beginning of period	463,964	428,111	441,761	366,727
Net assets, end of period	$468,026	$441,761	$468,026	$441,761

Certain FY2011 amounts have been reclassified to conform to the FY2012 presentation.

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

		6/30/12	6/30/11
Capitalization			
Current portion of long-term debt		$ 11,913	$ 9,273
Short-term notes payable			-
Long-term debt, less current portion	A	459,654	459,260
Total debt		471,567	468,533
Unrestricted net assets	B	458,218	434,661
Other net assets		9,808	7,100
Total net assets		468,026	441,761
Long-term debt plus Unrestricted net assets	A+B	$917,872	$ 893,921
Long-term debt to Capitalization	A/(A+B)	0.501	0.514
Debt Service Coverage			
Revenue and gains in excess of expenses and losses (12 months)		$ 39,820	$ 28,232
Add back:			
Depreciation and amortization (12 months)		46,403	46,059
Interest expense (12 months)		21,677	20,750
(Gain) loss from discontinued operations (12 months)		(88)	(44)
Total income available for debt service per Master Trust Indenture	C	107,812	94,997
Maximum annual debt service	D	$ 35,157	$ 35,157
Debt Service Coverage Ratio per Master Trust Indenture	C/D	3.07	2.70
Days Cash on Hand			
Unrestricted cash		$ 44,930	$ 36,558
Unrestricted investments:			
Capital improvements		297,981	273,886
Long-term investments		36,633	36,437
Less illiquid investments		(38,885)	(38,349)
	E	340,659	308,532
Operating expenses (12 months)		767,403	742,226
Less depreciation and amortization		(46,403)	(46,059)
Total cash expenses		721,000	696,167
Number of days in the period		366	365
Daily cash operating expenses	F	$ 1,970	$ 1,907
Days cash on hand	E/F	172.9	161.8

Certain FY2011 amounts have been reclassified to conform to the FY2012 presentation.

Wellmont Health System and Affiliates

Consolidated Balance Sheets as of
June 30, 2013 and June 30, 2012

Consolidated Statements of Operations and Changes in Net Assets and Statements of Cash Flows for the Quarters and Fiscal Years ended
June 30, 2013 and June 30, 2012

The following financial statements are unaudited but agree to the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2013

Volumes:

Quarter:

Volumes were mixed compared to the same quarter last year. Inpatients were down 948 or 9.7% and observation patients were up 638 or 19.1% (so total "patients in a bed" was down 310 or 2.4%) primarily due to reduced inpatient utilization from the implementation of the accountable care organizations in our area. Emergency room visits were down 10.8% due to Wellmont now having three urgent care centers as a more cost effective and patient friendly alternative, other outpatient volume was up 1.2%, and surgeries were down 3.5%. Deliveries were up 6.3% as a result of new physicians and physician office visits were up 14.0% primarily due to the urgent care centers.

Fiscal Year:

Volumes were also mixed compared to the prior fiscal year to date. Inpatients were down 2,323 or 5.8% and observation patients were up 72 or 0.5% (so total "patients in a bed" was down 2,251 or 4.2%) primarily due to reduced inpatient utilization from the implementation of the accountable care organizations in our area. Emergency room visits were down 6.7% due to Wellmont now having three urgent care centers as a more cost effective and patient friendly alternative, other outpatient volume was up 0.5%, and surgeries were down 2.6%. Deliveries were up 14.3% as a result of new physicians and physician office visits were up 17.2% primarily due to the urgent care centers and the acquisitions of a cardiology practice in October 2011 and a multispecialty practice in January 2012.

Statement of Operations:

Quarter ended June 30, 2013 versus quarter ended June 30, 2012:

Net patient service revenue increased $2.5 million or 1.3% from the same quarter last year. Other revenue decreased $11.4 million primarily as a result of $2.8 million of Electronic Health Record Meaningful Use amounts earned during the quarter being $10.0 million below prior year amounts of $12.8 million due to the timing of each facility's implementation.

Salaries and benefits increased $0.4 million or 0.4%. Hospital productivity remained flat as compared to the same quarter last year. Supplies increased $2.2 million or 5.4% due to a higher volume of orthopedic/spinal implant surgeries and robotic surgeries. Purchased services decreased $1.1 million or 5.2% due to changes in physician agreements. Interest expense decreased $0.3 million or 6.0%. Depreciation increased $0.5 million or 4.1%.

Income from operations of $1.9 million was below the same quarter last year by $9.6 million due to the $10.0 million decrease in Meaningful Use amounts earned during each quarter. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of $3.2 million was below the same quarter last year by $19.9 million

due to the $9.6 million decrease in income from operations, a $3.8 million decrease in investment income, a $4.4 million decrease in derivative valuation adjustments, and a $2.4 million increase in the loss from discontinued operations (due to the closure of certain sleep lab operations in this quarter).

Fiscal Year:

Net patient service revenue increased $14.0 million or 1.9% from the prior fiscal year. Other revenue decreased $4.2 million primarily as a result of lower volumes in subsidiaries providing services to hospitals such as laundry and blood services ($1.5 million) and lower earnings in an imaging joint venture ($1.3 million). Note that there was $13.7 million of Electronic Health Record Meaningful Use amounts earned this year which is essentially the same as the prior year amounts of $13.2 million.

Salaries and benefits increased $12.9 million or 3.5%, primarily driven by the physician practice growth and acquisitions and an increase in healthcare benefit costs due to increasing enrollment. Hospital productivity remained flat as compared to the prior fiscal year. Supplies decreased $0.4 million or 0.3%. Purchased services increased $1.4 million or 1.8% from several factors, the largest of which are from changes in the hospital physician services such as anesthesia (which was then decreased in the last quarter) and emergency medicine. Interest expense was essentially unchanged. Depreciation increased $5.0 million or 10.7% primarily for systems necessary to achieve Meaningful Use.

Income from operations of $12.9 million was below the prior fiscal year by $9.5 million. Net income (shown as “Revenues and gains in excess of expenses and losses attributable to Wellmont Health System”) of $31.4 million was below the prior fiscal year by $8.4 million due to the $9.5 million decrease in income from operations and a $2.1 million increase in the loss from discontinued operations (due to the closure of certain sleep lab operations), offset by a $2.2 million increase in investment income and a $0.5 million increase in derivative valuation adjustments.

Balance Sheet:

Days cash on hand increased primarily as a result of strong investment valuations, receipt of Meaningful Use funds, and net borrowings. The net borrowings consist of (a) $12.5 million taxable bank loan for the Epic implementation (fully drawn), (b) $42.5 million of tax exempt lease for the Epic implementation ($16.2 million drawn thus far), (c) $10 million lease line of credit ($5.2 million drawn thus far), less (d) regular debt and capital lease payments of $14.5 million. Other receivables decreased due to the receipt of the Meaningful Use amounts earned and accrued at June 30, 2012. The debt to capitalization ratio improved slightly due to the increase in net assets outweighing the impact of the net borrowings. The debt service coverage ratio dropped slightly due to the net borrowings.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics of the inpatient and other entities owned and operated by Wellmont for the quarters and fiscal years ended June 30, 2013 and June 30, 2012.

	FY13 QTR 4	FY12 QTR 4	FY13 YTD	FY12 YTD
Hospital Statistics:				
Acute Discharges	8,842	9,790	37,798	40,121
Observation Patients	3,982	3,344	13,741	13,669
Patients in Bed	12,824	13,134	51,539	53,790
Patient Days	36,499	41,495	162,459	173,533
Average Length of Stay (Days)	4.13	4.24	4.30	4.33
Daily Census including Observations	445	493	483	511
Emergency Room Visits	43,091	48,297	183,378	196,521
Outpatient Registrations excluding Observations, ER and Surgeries	53,379	52,761	210,044	209,024
Deliveries	560	527	2,309	2,021
Surgical Cases:				
Inpatient	2,309	2,346	9,101	9,176
Outpatient	6,326	6,606	25,118	25,957
Total Surgical Cases	8,635	8,952	34,219	35,133
Physician Office Visits	108,585	95,229	310,077	264,671

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2013 and June 30, 2012.

	FY13 All Year	FY12 All Year
Medicare	30.9%	32.1%
Medicare Managed Care	22.3%	20.8%
Medicaid	11.5%	11.4%
Managed Care	24.8%	25.3%
Self	7.6%	7.7%
Other	2.9%	2.7%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2013 and June 30, 2012
(Dollars in Thousands)(Unaudited)

	As of 6/30/13	As of 6/30/12
Assets		
Current assets:		
Cash and cash equivalents	$ 55,958	$ 44,930
Assets limited to use that are required for current liabilities	5,061	4,372
Patient accounts receivable	107,029	108,265
Other receivables	17,995	23,805
Inventories	18,361	17,862
Prepaid expenses & other current assets	8,949	7,462
Total current assets	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, net	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
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

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2013 and June 30, 2012
(Dollars in Thousands)(Unaudited)

	FY13 QTR 4	FY12 QTR 4	FY13 FYTD	FY12 FYTD
Revenue:				
Patient service revenue (net of contractual allowances and discounts)	206,684	209,538	809,517	811,882
Provision for bad debts	(16,158)	(21,464)	(55,029)	(71,407)
Net patient service revenue less provision for bad debts	190,526	188,074	754,488	740,475
Other revenue	9,960	21,352	43,735	47,904
Total revenue	200,486	209,426	798,223	788,379
Expenses:				
Salaries and benefits	96,866	96,505	381,210	368,288
Medical supplies and drugs	43,207	41,004	163,922	164,350
Purchased services	19,836	20,914	80,179	78,731
Interest	5,105	5,428	21,833	21,677
Depreciation and amortization	12,790	12,281	51,319	46,369
Other	20,749	21,741	86,816	86,501
Total expenses	198,553	197,873	785,279	765,916
Income from operations	1,933	11,553	12,944	22,463
Nonoperating gains (losses):				
Investment income	2,881	6,631	19,467	17,272
Derivative valuation adjustments	865	5,304	2,356	1,807
Nonoperating (losses), net	3,746	11,935	21,823	19,079
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	5,679	23,488	34,767	41,542
Discontinued operations	(2,253)	107	(2,167)	(52)
Revenues and gains in excess of expenses and losses	3,426	23,595	32,600	41,490
Income attributable to noncontrolling interests	(233)	(505)	(1,228)	(1,670)
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	3,193	23,090	31,372	39,820
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	(9,523)	(9,041)	6,157	(9,534)
Net assets released from restrictions for additions to land, buildings, and equipment	34	2,776	828	3,766
Change in the funded status of benefit plans and other	7,359	(10,495)	7,359	(10,495)
Increase (decrease) in unrestricted net assets	1,063	6,330	45,716	23,557
Changes in temporarily restricted net assets:				
Contributions	119	431	2,977	6,661
Net assets released from temporary restrictions	(239)	(2,963)	(1,789)	(4,492)
Increase in temporarily restricted net assets	(120)	(2,532)	1,188	2,169
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	1	128	7	130
Increase (decrease) in permanently restricted net assets	1	128	7	130
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	199	505	1,228	1,670
Distributions to noncontrolling interests	(20)	(369)	(1,220)	(1,261)
Increase (decrease) in noncontrolling interests	179	136	8	409
Change in net assets	1,123	4,062	46,919	26,265
Net assets, beginning of period	513,822	463,964	468,026	441,761
Net assets, end of period	$514,945	$468,026	$514,945	$468,026

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2013 and June 30, 2012
(Dollars in Thousands)(Unaudited)

	FY13 FYTD	FY12 FYTD
Cash flows from operating activities:		
Change in net assets	$ 46,919	$ 26,265
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	51,319	46,369
Net realized and unrealized (gains) losses on investments	(25,624)	(7,738)
Derivative valuation adjustments	(2,356)	(1,807)
(Gain) loss on sale of fixed assets	209	(458)
Increase (decrease) in cash due to changes in:		
Accounts Receivable	1,235	(6,700)
Inventories	(499)	(32)
Prepaid expenses and other current assets	3,634	(299)
Accounts payable and accrued expenses	3,056	10,300
Net decrease (increase) in other assets	(6,267)	(11,588)
Net cash provided by operating activities	71,626	54,312
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(68,209)	(44,305)
Transfer (to)/from Bond and Self-Insurance funds	8,230	1,122
Transfer (to)/from Board funds	(20,000)	(2,173)
Acquisitions	0	(813)
Net cash (used) in investing activities	(79,979)	(46,169)
Cash flows from financing activities:		
Proceeds from long term debt	33,855	11,368
Repayment of long term debt	(14,474)	(11,139)
Net cash provided (used) in financing activities	19,381	229
Increase (decrease) in cash and cash equivalents	11,028	8,372
Cash and cash equivalents, beginning	44,930	36,558
Cash and cash equivalents, ending	$ 55,958	$ 44,930

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

		6/30/13	6/30/12
Capitalization			
Current portion of long-term debt		$ 15,002	$ 11,913
Short-term notes payable			
Long-term debt, less current portion	A	475,946	459,654
Total debt		490,948	471,567
Unrestricted net assets	B	503,934	458,218
Other net assets		11,011	9,808
Total net assets		514,945	468,026
Long-term debt plus Unrestricted net assets	A+B	$979,880	$ 917,872
Long-term debt to Capitalization	A/(A+B)	0.486	0.501
Debt Service Coverage			
Revenue and gains in excess of expenses and losses (12 months)		$ 31,372	$ 39,820
Add back:			
Depreciation and amortization (12 months)		51,319	46,369
Interest expense (12 months)		21,833	21,677
(Gain) loss from discontinued operations (12 months)		2,167	52
Total income available for debt service per Master Trust Indenture	C	106,691	107,918
Maximum annual debt service	D	$ 41,310	$ 35,157
Debt Service Coverage Ratio per Master Trust Indenture	C/D	2.58	3.07
Days Cash on Hand			
Unrestricted cash		$ 55,958	$ 44,930
Unrestricted investments:			
Capital improvements		341,596	297,981
Long-term investments		28,628	36,633
Less illiquid investments		(27,528)	(38,621)
	E	398,654	340,923
Operating expenses (12 months)		785,279	765,916
Less depreciation and amortization		(51,319)	(46,369)
Total cash expenses		733,960	719,547
Number of days in the period		365	366
Daily cash operating expenses	F	$ 2,011	$ 1,966
Days cash on hand	E/F	198.3	173.4

Wellmont Health System and Affiliates

Consolidated Balance Sheets as of
June 30, 2014 and June 30, 2013

Consolidated Statements of Operations and Changes in Net Assets and Statements of Cash Flows for the Quarters and Fiscal Years ended
June 30, 2014 and June 30, 2013

The following financial statements are unaudited but agree to the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2014

Note that the closure of Lee Regional Medical Center on October 1, 2013 has been reflected as a discontinued operation for all periods presented.

Volumes:

Quarter ended June 30, 2014 versus quarter ended June 30, 2013:

Volumes were generally down compared to the same quarter last year. Inpatients were down 271 or 3.2% and observation patients were down 368 or 9.7% (so total "patients in a bed" were down 639 or 5.2%) primarily due to reduced utilization from the implementation of the accountable care organizations and high deductible plans in our area. Emergency room visits were up 3.1% and surgeries were down 4.1%, with all of the surgery decrease coming from the ambulatory surgery centers which is attributed to the increase in high deductible plans in our area. Deliveries were down 69 or 12.3% but this appears to be a random fluctuation. Physician office visits were flat overall, despite an increase of 27.3% in urgent care visits due to Wellmont now having four urgent care centers.

Fiscal Year:

Volumes were mixed compared to the prior fiscal year. Inpatients were down 2,066 or 5.7% and observation patients were up 1,192 or 9.2% (so total "patients in a bed" were down 874 or 1.8%) primarily due to reduced utilization from the implementation of the accountable care organizations and high deductible plans in our area. Emergency room visits were down 4.7% due to Wellmont now having four urgent care centers and surgeries were down 2.2%, with all of the surgery decrease coming from the ambulatory surgery centers which is attributed to the increase in high deductible plans in our area. Deliveries were down 99 or 4.3%. Physician office visits were up 2.6%, including urgent care visits which were up 30.5% due to Wellmont now having four urgent care centers.

Statement of Operations:

Quarter ended June 30, 2014 versus quarter ended June 30, 2013:

Net patient service revenue increased $1.7 million or 0.9% from the same quarter last year (bad debt is down but there is an offsetting increase in charity care in the line above). The acquisition of Wexford House and consolidation of Holston Valley Imaging Center added $6.4 million of net revenue, while the same store net revenue decreased $4.7 million due to Medicare reimbursement reductions and volume decreases.

Other revenue decreased $2.7 million primarily as a result of (a) $1.8 million of Electronic Health Record Meaningful Use amounts earned during the quarter being $0.6 million below the prior year amounts of $2.4 million due to the scheduled annual decreases in the program's payments, (b) blood bank revenue reductions of $0.9 million due to the loss of a significant contract, and (c) $0.4 million from lower performance of the managed care, home care and Takoma joint ventures.

Salaries and benefits increased slightly by $0.4 million or 0.4%. Supplies decreased $3.0 million or 7.0% primarily due to the lower volumes and increased savings from chemotherapy drugs. Purchased services increased slightly by $0.3 million or 1.6%. Interest expense decreased slightly by $0.3 million or 5.9% due to the capitalization of interest for the Epic electronic health record project and scheduled decreases in outstanding principal. Depreciation increased by $2.0 million or 16.1% due to the Epic system going live at the beginning of April. Lease and rental decreased by $0.7 million or 15.7% due to the conversion of some operating leases to capital leases. Other expenses increased by $4.4 million or 84% primarily due to an increase in the professional and general liability actuarial expense of $3.3 million and to the change in allocation of support services costs as a result of the closure of Lee Regional Medical Center.

The loss from operations of ($1.3 million) was worse than the same quarter last year by $3.8 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of $3.6 million was above the same quarter last year by $0.5 million due primarily to a $4.7 million increase in investment income and a $1.8 million decrease in the loss from discontinued operations, offset by a $0.7 million decrease in derivative valuation adjustments, a $1.1 million loss on refinancing, and the $3.8 million decrease in income from operations.

Fiscal Year:

Net patient service revenue increased $5.3 million or 0.7% compared to the prior fiscal year (bad debt is down but there is an offsetting increase in charity care in the line above). The acquisition of Wexford House and consolidation of Holston Valley Imaging Center added $11.3 million of net revenue, while the same store net revenue decreased $6.0 million due to Medicare reimbursement reductions and volume decreases.

Other revenue decreased $12.7 million primarily as a result of (a) $7.2 million of Electronic Health Record Meaningful Use amounts earned being $5.1 million below the prior year amounts of $12.3 million due to the scheduled annual decreases in the program's payments, (b) blood bank revenue reductions of $3.4 million due to the loss of a significant contract, and (c) $1.9 million from lower performance of the managed care, home care and Takoma joint ventures.

Salaries and benefits increased slightly by $1.2 million or 0.3%. Supplies increased $4.1 million or 2.5% primarily in chemotherapy drug volume and cost. Purchased services decreased $4.0 million or 5.2% due to changes in physician agreements. Interest expense decreased by $1.9 million or 9.6% due to the capitalization of interest for the Epic electronic health record project and scheduled decreases in outstanding principal. Depreciation increased by $0.6 million or 1.2%. Lease and rental decreased by $2.4 million or 13.3% due to the conversion of some operating leases to capital leases. Other expenses increased $5.6 million or 20.8% primarily

due to an increase in the professional and general liability expense of $3.5 million and to the change in allocation of support services costs as a result of the closure of Lee Regional Medical Center.

Income from operations of $4.8 million was below the prior fiscal year to date by $10.6 million. Net income (shown as “Revenues and gains in excess of expenses and losses attributable to Wellmont Health System”) of $6.3 million was below the prior fiscal year by $25.0 million due to the impairment of Lee Regional Medical Center of $22.5 million included in the $26.6 million loss on discontinued operations, the $10.6 million decrease in income from operations, a $4.6 million decrease in investment income, a $1.1 million loss on refinancing, and a $1.0 million decrease in derivative valuation adjustments, offset by the $14.7 million gain on conversion from the equity method to consolidation of Holston Valley Imaging Center on March 31, 2014.

Balance Sheet and Ratios:

The significant changes in the balance sheet were (a) expenditures for the Epic electronic health record project of $60.2 million and draws on the financing thereof of $26.7 million, (b) the acquisition of Wexford House of $13.5 million ($5.8 million land, buildings and equipment and $7.7 million goodwill), (c) the acquisition of the remaining 25% of Holston Valley Imaging Center of $7.9 million (all goodwill), (d) the associated conversion of Holston Valley Imaging Center from the equity method to consolidation which resulted in an increase in goodwill of $21.5 million, (e) the impairment of Lee Regional Medical Center of $22.5 million ($21.7 million buildings and equipment and $0.8 million goodwill) and (f) the sale of Wellmont Health System’s 60% interest in Takoma Regional Hospital of $11.7 million as of July 1, 2014 (the cash was received on June 30, 2014 and is in other current liabilities). In addition, the 2003, 2005 and 2010 series of debt were refinanced in June with new direct placement tax-exempt debt.

Days cash on hand increased as a result of the above activity and appreciation of the investment portfolio. The debt to capitalization ratio improved slightly. The debt service coverage ratio decreased due to income available for debt service being $17.8 million lower and MADS being $1.5 million higher.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics for the quarters and fiscal ye ended June 30, 2014 and June 30, 2013 (restated to remove Lee Regional as it is now a discontinued operation).

	FY14 QTR 4	FY13 QTR 4	FY14 All Year	FY13 All Year
Hospital Statistics:				
Acute Discharges	8,300	8,571	34,365	36,431
Observation Patients	3,430	3,798	14,205	13,013
Patients in Bed	11,730	12,369	48,570	49,444
Patient Days	35,882	35,606	145,845	157,541
Average Length of Stay (Days)	4.32	4.15	4.24	4.32
Daily Census including Observations	432	433	438	467
Emergency Room Visits	43,463	42,140	170,331	178,691
Deliveries	491	560	2,210	2,309
Surgical Cases:				
Inpatient	2,391	2,341	9,430	9,279
Outpatient	6,103	6,517	24,896	25,804
Total Surgical Cases	8,494	8,858	34,326	35,083
Physician Office Visits	108,976	108,847	429,656	418,924
including Urgent Care Visits	12,424	9,763	44,344	33,993

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2014 and June 30, 2013.

	FY14 All Year	FY13 All Year
Medicare	30.7%	31.0%
Medicare Managed Care	23.6%	23.5%
Medicaid	11.1%	10.9%
Managed Care/Other	27.7%	27.9%
Self	6.9%	6.7%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2014 and June 30, 2013
(Dollars in Thousands)(Unaudited)

	As of 6/30/14	As of 6/30/13
Assets		
Current assets:		
Cash and cash equivalents	$ 30,674	$ 55,958
Assets limited to use that are required for current liabilities	3,233	5,061
Patient accounts receivable	117,265	107,029
Other receivables	14,685	17,995
Inventories	18,684	18,361
Prepaid expenses & other current assets	10,337	8,949
Total current assets	194,878	213,353
Assets limited as to use, net of current portion	425,740	375,709
Land, buildings and equipment, net	492,581	474,730
Other assets:		
Long-term investments	32,521	28,628
Investments in affiliates	18,221	31,874
Deferred debt expense, net	4,226	5,178
Goodwill, net	51,649	15,096
Other	520	547
	107,137	81,323
Total assets	$ 1,220,336	$ 1,145,115
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ 18,015	$ 15,002
Accounts payable and accrued expenses	90,547	84,300
Estimated third-party payor settlements	8,425	7,157
Current portion of other long-term liabilities	6,510	6,198
Other current liabilities	11,700	0
Total current liabilities	135,197	112,657
Long-term debt, less current portion	490,443	475,946
Other long-term liabilities, less current portion	43,866	41,567
Total liabilities	669,506	630,170
Net assets:		
Unrestricted	538,607	503,934
Temporarily restricted	8,214	6,927
Permanently restricted	1,319	1,311
Noncontrolling interests	2,690	2,773
Total net assets	550,830	514,945
Commitments and contingencies		
Total liabilities and net assets	$ 1,220,336	$ 1,145,115

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2014 and June 30, 2013
(Dollars in Thousands)(Unaudited)

	FY14 QTR 4	FY13 QTR 4	FY14 All Year	FY13 All Year
Revenue:				
Patient service revenue (net of contractual allowances and discounts)	$193,547	$201,740	788,910	791,230
Provision for bad debts	(5,396)	(15,323)	(45,644)	(53,251)
Net patient service revenue less provision for bad debts	188,151	186,417	743,266	737,979
Other revenue	6,841	9,507	29,441	42,127
Total revenue	194,992	195,924	772,707	780,106
Expenses:				
Salaries and benefits	95,323	94,963	374,309	373,150
Medical supplies and drugs	39,850	42,850	166,676	162,604
Purchased services	19,537	19,231	73,674	77,716
Interest	4,441	4,720	18,350	20,292
Depreciation and amortization	14,310	12,330	50,058	49,465
Maintenance and utilities	9,303	9,497	36,978	36,830
Lease and rental	3,840	4,554	15,506	17,892
Other	9,722	5,284	32,312	26,745
Total expenses	196,326	193,429	767,863	764,694
Income (loss) from operations	(1,334)	2,495	4,844	15,412
Nonoperating gains (losses):				
Investment income	7,531	2,879	14,749	19,316
Derivative valuation adjustments	189	865	1,307	2,356
Loss on refinancing	(1,133)	-	(1,133)	-
Gain on revaluation of equity method investment	-	-	14,744	-
Nonoperating gains (losses), net	6,587	3,744	29,667	21,672
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	5,253	6,239	34,511	37,084
Discontinued operations	(1,128)	(2,943)	(26,639)	(4,484)
Revenues and gains in excess of expenses and losses	4,125	3,296	7,872	32,600
Income attributable to noncontrolling interests	(571)	(234)	(1,540)	(1,228)
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	3,554	3,062	6,332	31,372
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	7,968	(9,426)	28,333	6,157
Net assets released from restrictions for additions to land, buildings, and equipment	(192)	34	901	828
Change in funded status of benefit plans and other	(893)	7,359	(893)	7,359
Increase (decrease) in unrestricted net assets	10,437	1,029	34,673	45,716
Changes in temporarily restricted net assets:				
Contributions	454	217	2,707	2,977
Net assets released from temporary restrictions	99	(337)	(1,420)	(1,789)
Increase (decrease) in temporarily restricted net assets	553	(120)	1,287	1,188
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	5	1	8	7
Increase in permanently restricted net assets	5	1	8	7
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	571	234	1,540	1,228
Distributions to noncontrolling interests	(307)	(21)	(1,623)	(1,220)
Increase (decrease) in noncontrolling interests	264	213	(83)	8
Change in net assets	11,259	1,123	35,885	46,919
Net assets, beginning of period	539,571	513,822	514,945	468,026
Net assets, end of period	$550,830	$514,945	$550,830	$514,945

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2014 and June 30, 2013
(Dollars in Thousands)(Unaudited)

	FY14 All Year	FY13 All Year
Cash flows from operating activities:		
Change in net assets	$ 35,885	$ 46,919
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	50,058	49,465
Net realized and unrealized (gains) losses on investments	(43,082)	(25,473)
Derivative valuation adjustments	(1,307)	(2,356)
(Gain) loss on sale of fixed assets	(78)	209
Loss on refinancing	1,133	0
(Gain) on revaluation of equity method investment	(14,744)	0
Impairment of assets	22,456	0
Increase (decrease) in cash due to changes in:		
Accounts Receivable	(10,236)	1,235
Inventories	(323)	(499)
Prepaid expenses and other current assets	3,750	3,634
Accounts payable and accrued expenses	7,498	3,056
Net decrease (increase) in other assets	3,723	(4,564)
Net cash provided by operating activities	54,733	71,626
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(69,074)	(68,209)
Transfer (to)/from Bond and Self-Insurance funds	(5,837)	8,230
Transfer (to)/from Board funds	0	(20,000)
Acquisitions	(22,637)	0
Net cash (used) in investing activities	(97,548)	(79,979)
Cash flows from financing activities:		
Proceeds from long term debt	128,623	33,855
Repayment of long term debt	(111,092)	(14,474)
Net cash provided (used) in financing activities	17,531	19,381
Increase (decrease) in cash and cash equivalents	(25,284)	11,028
Cash and cash equivalents, beginning	55,958	44,930
Cash and cash equivalents, ending	$ 30,674	$ 55,958

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

		6/30/14	6/30/13
Capitalization			
Current portion of long-term debt		$ 18,015	$ 15,002
Short-term notes payable			
Long-term debt, less current portion	A	490,443	475,946
Total debt		508,458	490,948
Unrestricted net assets	B	538,607	503,934
Other net assets		12,223	11,011
Total net assets		550,830	514,945
Long-term debt plus Unrestricted net assets	A+B	$ 1,029,050	$ 979,880
Long-term debt to Capitalization	A/(A+B)	0.477	0.486
Debt Service Coverage			
Revenue and gains in excess of expenses and losses (12 months)		$ 6,332	$ 31,372
Add back:			
Depreciation and amortization		50,058	49,465
Interest expense		18,350	20,292
Loss on refinancing		1,133	-
(Gain) on revaluation of equity method investment		(14,744)	-
Loss from discontinued operations		26,639	4,484
Total income available for debt service per Master Trust Indenture	C	87,768	105,613
Maximum annual debt service	D	$ 42,797	$ 41,310
Debt Service Coverage Ratio per Master Trust Indenture	C/D	2.05	2.56
Days Cash on Hand			
Unrestricted cash		$ 30,674	$ 55,958
Unrestricted investments:			
Capital improvements		383,962	341,596
Long-term investments		32,521	28,628
Less illiquid investments		(28,364)	(27,528)
	E	418,793	398,654
Operating expenses (12 months)		767,863	764,694
Less depreciation and amortization		(50,058)	(49,465)
Total cash expenses		717,805	715,229
Number of days in the period		365	365
Daily cash operating expenses	F	$ 1,967	$ 1,960
Days cash on hand	E/F	213.0	203.4

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates

Consolidated Balance Sheets as of
June 30, 2015 and June 30, 2014

Consolidated Statements of Operations and Changes in Net Assets and Statements of Cash Flows for the Quarters and Fiscal Years ended
June 30, 2015 and June 30, 2014

The following financial statements are unaudited but agree to the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2015

Note that the closure of Lee Regional Medical Center on October 1, 2013 has been reflected as a discontinued operation for all periods presented.

Overview:

Wellmont Health System had income from operations of $6.7 million and net income of $15.4 million for the fiscal year ended June 30, 2015. Net patient service revenue increased 6.4%. Adjusting to the trend of more care delivered in outpatient facilities, Wellmont has opened additional urgent care centers, which have provided a way for patients to receive assistance for pressing health needs that can be addressed without an expensive trip to the emergency department. This also reflects the health system's goal to increase health care access points in the area and reshape the way the region receives care in lower cost outpatient settings. That has resulted in a 56% increase in urgent care patient volumes during fiscal 2015, when a new center opened in Lebanon, Virginia, and the Bristol and Kingsport, Tennessee centers operated for their first full years. The health system also operates urgent care centers in Johnson City, Tennessee; Abingdon, Virginia; and Norton, Virginia. The opening of another facility for cancer patients, this one in Bristol, Virginia, further extended Wellmont's community outreach. Open since January, this facility features services such as oncology, hematology, genetic counseling, high-risk cancer clinic, clinical trials, nutrition services and social work. This is the fifth office for the Wellmont Cancer Institute. During fiscal 2015, the number of infusion patient visits across the system increased by 64%. The following volume and financial details provide additional information on Wellmont's growing strength in service to the community.

Volumes:

Total patients in a bed were up 1.2% for the year as we continue the transition to value based payments while facing the challenge of increasingly prevalent high deductible health plans in our area. While emergency room visits were up 4.7%, surgeries were down 2.3% and deliveries were up 1.6%. Outpatient volumes were up, especially due to the expansion of infusion centers (visits up 64%) and urgent care centers (visits up 56% for year) as we continue to expand the portals of entry into our health system.

Statement of Operations:

Quarter ended June 30, 2015 versus quarter ended June 30, 2014:

Net patient service revenue increased $17.3 million or 9.2% from the same quarter last year due primarily to a 13.2% increase in outpatient revenue. Other revenue decreased $1.5 million primarily as a result of (a) $0.6 million of Electronic Health Record Meaningful Use amounts earned during the quarter being $1.2 million below the prior year amounts of $1.8 million due to reduced payments from lower volumes and the scheduled annual decreases in the program's payments and (b) blood bank revenue reductions of $0.3 million due to the loss of a significant contract.

Salaries and benefits increased $12.8 million or 13.5% as a result of (a) one-time five year physician retention compensation earned and (b) an increase in employee health costs for the last quarter due to higher utilization. Supplies increased 5.3% primarily due to higher infusion volumes. Purchased services decreased 2.3%. Interest expense decreased 0.3%. Depreciation increased 7.8% due to the Epic system going live in April 2014. All other expenses decreased 10.9% due primarily to a significantly lower professional and general liability expense from the preliminary actuarial report.

Income from operations of $1.4 million was above the same quarter last year by $2.7 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of $1.6 million was below the same quarter last year by $2.0 million.

Fiscal Year:

Net patient service revenue increased $47.7 million or 6.4% compared to the prior fiscal year due to (a) the Wexford House acquisition in December 2013 and the HVIC acquisition at the end of March 2014 and (b) the increase in outpatient revenue. Other revenue decreased $7.7 million primarily as a result of (a) $3.2 million of Electronic Health Record Meaningful Use amounts earned being $4.0 million below the prior year amounts of $7.2 million due to reduced payments from lower volumes and the scheduled annual decreases in the program's payments, (b) blood bank revenue reductions of $1.7 million due to the loss of a significant contract, and (c) $3.0 million decrease from the prior investment in HVIC now being consolidated in each line of the statement of operations.

Salaries and benefits increased $25.6 million or 6.9% as a result of (a) the acquisitions noted above and (b) one-time five year physician retention compensation earned. Supplies were up 1.2%. Purchased services increased 2.8%. Interest expense decreased 3.2%. Depreciation increased $8.5 million or 17.0% due to the Epic system going live in April 2014. All other expenses increased 0.6%.

Income from operations of $6.7 million was above the prior fiscal year by $1.9 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of $15.4 million was above the prior fiscal year by $9.0 million. The prior fiscal year was impacted by (a) the impairment of Lee Regional Medical Center of $22.5 million included in the $26.6 million of discontinued operations, offset somewhat by (b) the $14.7 million gain on conversion from equity to consolidation for the HVIC acquisition.

Balance Sheet and Ratios:

The only significant changes in the balance sheet were the sale of Wellmont Health System's 60% interest in Takoma Regional Hospital of $11.7 million as of July 1, 2014 (the cash was received on June 30, 2014 and was in other current liabilities). In addition, a portion of the Series 2006C debt was advance refunded in September 2014 with new direct placement tax-exempt debt. Cash on hand decreased by 2 days and the debt to capitalization ratio and debt service coverage ratio both improved slightly.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics for the quarters and fiscal years ended June 30, 2015 and June 30, 2014.

	FY15 QTR 4	FY14 QTR 4	FY15 All Year	FY14 All Year
Hospital Statistics:				
Acute Discharges	7,980	8,300	33,045	34,356
Observation Patients	4,570	3,430	16,693	14,779
Patients in Bed	12,550	11,730	49,738	49,135
Patient Days	33,661	35,882	144,579	145,845
Average Length of Stay (Days)	4.22	4.32	4.38	4.25
Daily Census including Observations	420	432	442	440
Emergency Room Visits	45,433	43,463	178,324	170,331
Deliveries	448	491	2,246	2,210
Surgical Cases:				
Inpatient	2,239	2,391	9,125	9,430
Outpatient	5,932	6,103	24,396	24,896
Total Surgical Cases	8,171	8,494	33,521	34,326
Physician Office Visits	123,390	108,976	474,762	429,656
including Urgent Care Visits	16,902	12,424	69,421	44,344

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2015 and June 30, 2014.

	FY15 All Year	FY14 All Year
Medicare	30.6%	30.7%
Medicare Managed Care	23.4%	23.6%
Medicaid	11.3%	11.1%
Managed Care/Other	27.9%	27.7%
Self	6.8%	6.9%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2015 and June 30, 2014
(Dollars in Thousands)(Unaudited)

	As of 6/30/15	As of 6/30/14
Assets		
Current assets:		
Cash and cash equivalents	$ 48,866	$ 30,674
Assets limited to use that are required for current liabilities	3,651	4,066
Patient accounts receivable	112,299	117,265
Other receivables	11,238	14,685
Inventories	19,981	18,684
Prepaid expenses & other current assets	9,979	10,337
Total current assets	206,014	195,711
Assets limited as to use, net of current portion	424,864	424,907
Land, buildings and equipment, net	484,569	492,581
Other assets:		
Long-term investments	27,964	32,521
Investments in affiliates	7,214	18,221
Deferred debt expense, net	4,217	4,226
Goodwill, net	51,583	51,649
Other	525	520
	91,503	107,137
Total assets	$ 1,206,950	$ 1,220,336
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ 18,626	$ 18,015
Accounts payable and accrued expenses	101,871	90,547
Estimated third-party payor settlements	12,987	8,425
Current portion of other long-term liabilities	7,660	6,510
Other current liabilities	0	11,700
Total current liabilities	141,144	135,197
Long-term debt, less current portion	480,187	490,443
Other long-term liabilities, less current portion	39,097	43,866
Total liabilities	660,428	669,506
Net assets:		
Unrestricted	535,632	538,607
Temporarily restricted	6,960	8,214
Permanently restricted	1,323	1,319
Noncontrolling interests	2,607	2,690
Total net assets	546,522	550,830
Commitments and contingencies		
Total liabilities and net assets	$ 1,206,950	$ 1,220,336

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2015 and June 30, 2014
(Dollars in Thousands)(Unaudited)

	FY15 QTR 4	FY14 QTR 4	FY15 All Year	FY14 All Year
Revenue:				
Net patient service revenue less provision for bad debts	$ 205,481	$ 188,151	$ 790,970	$ 743,266
Other revenue	5,300	6,841	21,759	29,441
Total revenue	210,781	194,992	812,729	772,707
Expenses:				
Salaries and benefits	108,150	95,323	399,955	374,309
Medical supplies and drugs	41,977	39,850	168,678	166,676
Purchased services	19,086	19,537	75,749	73,674
Interest	4,428	4,441	17,757	18,350
Depreciation and amortization	15,428	14,310	58,569	50,058
Maintenance and utilities	10,039	9,303	39,764	36,978
Lease and rental	4,046	3,840	15,435	15,506
Other	6,272	9,722	30,128	32,312
Total expenses	209,426	196,326	806,035	767,863
Income from operations	1,355	(1,334)	6,694	4,844
Nonoperating gains (losses):				
Investment income	2,528	7,531	14,207	14,749
Derivative valuation adjustments	(1,697)	189	(563)	1,307
Gain on revaluation of equity method investment	-	-	-	14,744
Loss on refinancing	-	(1,133)	(1,389)	(1,133)
Nonoperating gains (losses), net	831	6,587	12,255	29,667
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	2,186	5,253	18,949	34,511
Discontinued operations	(532)	(1,128)	(2,720)	(26,639)
Revenues and gains in excess of expenses and losses	1,654	4,125	16,229	7,872
Income attributable to noncontrolling interests	(73)	(571)	(866)	(1,540)
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	1,581	3,554	15,363	6,332
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	(4,160)	7,968	(18,555)	28,333
Net assets released from restrictions for additions to land, buildings, and equipment	384	(192)	2,712	901
Change in funded status of benefit plans and other	(2,495)	(893)	(2,495)	(893)
Increase (decrease) in unrestricted net assets	(4,690)	10,437	(2,975)	34,673
Changes in temporarily restricted net assets:				
Contributions	170	454	2,545	2,707
Net assets released from temporary restrictions	(668)	99	(3,799)	(1,420)
Increase (decrease) in temporarily restricted net assets	(498)	553	(1,254)	1,287
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	1	5	4	8
Increase (decrease) in permanently restricted net assets	1	5	4	8
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	73	571	866	1,540
Distributions to noncontrolling interests	(337)	(307)	(949)	(1,623)
Increase (decrease) in noncontrolling interests	(264)	264	(83)	(83)
Change in net assets	(5,451)	11,259	(4,308)	35,885
Net assets, beginning of period	551,973	539,571	550,830	514,945
Net assets, end of period	$ 546,522	$ 550,830	$ 546,522	$ 550,830

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2015 and June 30, 2014
(Dollars in Thousands)(Unaudited)

	FY15 All Year	FY14 All Year
Cash flows from operating activities:		
Change in net assets	$ (4,308)	$ 35,885
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	58,569	50,058
Net realized and unrealized (gains) losses on investments	4,348	(43,082)
Derivative valuation adjustments	563	(1,307)
(Gain) loss on sale of fixed assets	(569)	(78)
(Gain) on conversion from equity to consolidation	0	(14,744)
Loss on refinancing	1,389	1,133
Impairment of assets	0	22,456
Increase (decrease) in cash due to changes in:		
Accounts Receivable	4,966	(10,236)
Inventories	(1,297)	(323)
Prepaid expenses and other current assets	3,731	3,750
Accounts payable and accrued expenses	(375)	7,498
Net decrease (increase) in other assets	11,476	3,723
Net cash provided by operating activities	78,493	54,733
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(50,054)	(69,074)
Transfer (to)/from Bond and Self-Insurance funds	(602)	(5,837)
Transfer (to)/from Board funds	0	0
Acquisitions	0	(22,637)
Net cash (used) in investing activities	(50,656)	(97,548)
Cash flows from financing activities:		
Proceeds from long term debt	26,064	128,623
Repayment of long term debt	(35,709)	(111,092)
Net cash provided (used) in financing activities	(9,645)	17,531
Increase (decrease) in cash and cash equivalents	18,192	(25,284)
Cash and cash equivalents, beginning	30,674	55,958
Cash and cash equivalents, ending	$ 48,866	$ 30,674

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

		6/30/15	6/30/14
Capitalization			
Current portion of long-term debt		$ 18,626	$ 18,015
Short-term notes payable			
Long-term debt, less current portion	A	480,187	490,443
Total debt		498,813	508,458
Unrestricted net assets	B	535,632	538,607
Other net assets		10,890	12,223
Total net assets		546,522	550,830
Long-term debt plus Unrestricted net assets	A+B	$ 1,015,819	$ 1,029,050
Long-term debt to Capitalization	A/(A+B)	0.473	0.477
Debt Service Coverage			
Revenue and gains in excess of expenses and losses (12 months)		$ 15,363	$ 6,332
Add back:			
Depreciation and amortization (12 months)		58,569	50,058
Interest expense (12 months)		17,757	18,350
(Gain) loss on refinancing		1,389	1,133
(Gain) on revaluation of equity method investment		-	(14,744)
(Gain) loss from discontinued operations (12 months)		2,720	26,639
Total income available for debt service per Master Trust Indenture	C	95,798	87,768
Maximum annual debt service	D	$ 43,009	$ 42,797
Debt Service Coverage Ratio per Master Trust Indenture	C/D	2.23	2.05
Days Cash on Hand			
Unrestricted cash		$ 48,866	$ 30,674
Unrestricted investments:			
Capital improvements		382,902	383,962
Long-term investments		27,964	32,521
Less illiquid investments		(28,051)	(28,364)
	E	431,681	418,793
Operating expenses (12 months)		806,035	767,863
Less depreciation and amortization		(58,569)	(50,058)
Total cash expenses		747,466	717,805
Number of days in the period		365	365
Daily cash operating expenses	F	$ 2,048	$ 1,967
Days cash on hand	E/F	210.8	213.0

Exhibit 11.5 - Attachment D

The Wellmont External Auditor Management Letters are considered confidential information.

Exhibit 11.5

Attachment E

Wellmont - Rating Agencies Reports

STANDARD &POOR'S

RATINGSDIRECT®

August 24, 2009

Wellmont Health System, Tennessee; System

Primary Credit Analyst:
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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

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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.

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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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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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RATINGS SERVICES

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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+/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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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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STANDARD & POOR'S RATINGS SERVICES
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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

STANDARD & POOR'S RATINGS SERVICES
McGRAW HILL FINANCIAL

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.

Exhibit 11.7

The current annual budget for Wellmont is considered competitively sensitive information under federal antitrust laws.

Exhibit 11.8

Five Year Projected Budget for the New Health System

Submitted on February 16, 2016

and

Updated Financial Model

*Submitted on July 13, 2016 as **Exhibit 35** to Response #1 to Questions Submitted April 22, 2016 by Tennessee Department of Health*

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 35

Updated Financial Model

Income Statement - NewCo Baseline	Actuals			Forecasted				
$'000s	FYE 6/13	FYE 6/14	FYE 6/15	Year 1	Year 2	Year 3	Year 4	Year 5
Net patient service revenue ("NPSR")	**$ 1,670,727**	**$ 1,671,050**	**$ 1,813,472**	**$ 1,812,747**	**$ 1,886,737**	**$ 1,924,471**	**$ 1,962,961**	**$ 2,002,220**
Other revenues:								
Other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total other revenues	**120,585**	**102,581**	**90,756**	**90,756**	**90,756**	**90,756**	**90,756**	**90,756**
Total revenue, gains, & support	**1,791,312**	**1,773,631**	**1,904,228**	**1,903,502**	**1,977,492**	**2,015,227**	**2,053,716**	**2,092,976**
Expenses:								
Salaries, wages, & benefits	881,530	865,989	925,061	936,615	948,313	960,157	972,150	984,292
Medical supplies & drugs	325,559	330,375	344,718	346,269	362,169	371,224	380,504	390,017
Purchased services	183,607	189,280	196,037	201,918	207,975	214,215	220,641	227,260
Interest & taxes	63,495	62,742	61,453	59,338	57,756	56,216	54,717	53,258
Depreciation & amortization	130,666	121,237	127,336	126,507	126,364	126,828	127,872	129,471
Maintenance & utilities	53,687	54,030	56,561	58,258	60,006	61,806	63,660	65,570
Lease & rental	17,892	15,506	15,435	15,821	16,216	16,622	17,037	17,463
Other	107,995	122,584	143,924	149,681	155,668	161,895	168,371	175,105
Total expenses & losses	**1,764,431**	**1,761,743**	**1,870,524**	**1,894,407**	**1,934,468**	**1,968,962**	**2,004,952**	**2,042,436**
Income from operations	**26,881**	**11,888**	**33,704**	**9,095**	**43,024**	**46,265**	**48,765**	**50,540**
Non-operating gains:								
Investment income	60,296	65,452	4,883	23,099	23,561	24,032	24,512	25,003
Derivative valuation adjustments	9,474	4,526	19,093	-	-	-	-	-
Loss on refinancing	-	(5,755)	(1,389)	-	-	-	-	-
Gain on revaluation of equity method investment	-	14,744	-	-	-	-	-	-
Non-operating gains, net	**69,770**	**78,967**	**22,587**	**23,099**	**23,561**	**24,032**	**24,512**	**25,003**
Revenues & gains in excess of expenses & losses	**96,651**	**90,855**	**56,291**	**32,194**	**66,585**	**70,296**	**73,277**	**75,542**
Other non-operating items:								
Discontinued operations	(4,484)	(26,639)	(2,720)	-	-	-	-	-
Income attributable to non-controlling interest	(7,728)	(9,826)	(15,046)	(14,483)	(14,999)	(15,054)	(15,099)	(15,133)
Total other non-operating operations	**(12,212)**	**(36,465)**	**(17,765)**	**(14,483)**	**(14,999)**	**(15,054)**	**(15,099)**	**(15,133)**
Revenues & gains in excess of expenses & losses attributable to	**$ 84,439**	**$ 54,390**	**$ 38,526**	**$ 17,711**	**$ 51,586**	**$ 55,242**	**$ 58,178**	**$ 60,409**

Balance Sheet - NewCo Baseline	Actuals			Forecasted				
$'000s	6/30/13	6/30/14	6/30/15	Year 1	Year 2	Year 3	Year 4	Year 5
Current assets:								
Cash & cash equivalents	$ 130,860	$ 89,859	$ 128,580	$ 99,994	$ 90,690	$ 85,045	$ 76,870	$ 65,621
Current portion of investments	25,447	28,262	22,904	22,904	22,904	22,904	22,904	22,904
Patient accounts receivable, net	271,216	278,583	274,678	273,154	284,303	289,989	295,789	301,704
Other receivables, net	51,463	60,187	41,588	43,667	45,851	48,143	50,551	53,078
Inventories & prepaid expenses	58,383	59,859	63,930	61,664	64,496	66,108	67,761	69,455
Total current assets	**537,370**	**516,750**	**531,680**	**501,384**	**508,243**	**512,190**	**513,875**	**512,762**
Other non-current assets:								
Long-term investments	1,037,563	1,124,957	1,154,927	1,178,026	1,201,586	1,225,618	1,250,131	1,275,133
Property, plant, & equipment, net	1,359,023	1,374,010	1,331,657	1,330,150	1,335,035	1,346,020	1,362,851	1,385,318
Goodwill	169,487	208,262	208,179	208,179	208,179	208,179	208,179	208,179
Net deferred financing, acquisition costs & other charges	33,658	30,067	28,972	27,523	26,147	24,840	23,598	22,418
Other assets	47,091	48,870	53,567	55,174	56,830	58,534	60,290	62,099
Total other non-current assets	**2,646,822**	**2,786,166**	**2,777,303**	**2,799,052**	**2,827,778**	**2,863,191**	**2,905,049**	**2,953,148**
Total assets	**3,184,192**	**3,302,916**	**3,308,983**	**3,300,436**	**3,336,021**	**3,375,381**	**3,418,924**	**3,465,910**
Current liabilities:								
Current portion of debt & liabilities	75,323	73,791	84,731	84,731	84,731	84,731	84,731	84,731
Accounts payable & accrued expenses	242,267	261,554	270,782	268,682	275,199	280,683	286,301	292,056
Estimated third-party payor settlements	33,932	18,888	18,471	18,841	19,217	19,602	19,994	20,394
Total current liabilities	**351,523**	**354,233**	**373,985**	**372,254**	**379,148**	**385,017**	**391,027**	**397,181**
Non-current liabilities:								
Long-term debt & liabilities	1,566,294	1,565,512	1,524,098	1,483,455	1,443,897	1,405,393	1,367,915	1,331,438
Retention bonus liability	-	-	-	-	-	-	-	-
Other long-term liabilities	78,447	99,400	81,633	83,265	84,931	86,629	88,362	90,129
Total non-current liabilities	**1,644,740**	**1,664,912**	**1,605,731**	**1,566,721**	**1,528,827**	**1,492,022**	**1,456,277**	**1,421,567**
Total liabilities	**1,996,263**	**2,019,145**	**1,979,715**	**1,938,975**	**1,907,975**	**1,877,038**	**1,847,304**	**1,818,748**
Net assets:								
Unrestricted	994,348	1,080,586	1,112,232	1,129,943	1,181,529	1,236,771	1,294,949	1,355,358
Temporarily restricted	19,703	20,418	20,508	20,508	20,508	20,508	20,508	20,508
Permanently restricted	1,438	1,446	1,450	1,450	1,450	1,450	1,450	1,450
Noncontrolling interests	172,439	181,321	195,078	209,560	224,559	239,614	254,713	269,846
Total net assets	**1,187,929**	**1,283,771**	**1,329,268**	**1,361,462**	**1,428,046**	**1,498,343**	**1,571,620**	**1,647,162**
Total liabilities and net assets	**$ 3,184,192**	**$ 3,302,916**	**$ 3,308,983**	**$ 3,300,436**	**$ 3,336,021**	**$ 3,375,381**	**$ 3,418,924**	**$ 3,465,910**

Statement of Cash Flows - NewCo Baseline		Forecasted				
$'000s	Scenario	Year 1	Year 2	Year 3	Year 4	Year 5
Cash flows from operating activities:						
Income from operations		$ 9,095	$ 43,024	$ 46,265	$ 48,765	$ 50,540
Adjustments to reconcile change in net assets to net cash provided by operating activities:						
Depreciation and amortization		126,507	126,364	126,828	127,872	129,471
Loss on extinguishment of debt		-	-	-	-	-
Change in estimated fair value of derivatives		-	-	-	-	-
Equity in net income of JVs, net		-	-	-	-	-
Loss/(Gain) on disposal of assets		-	-	-	-	-
Capital Appreciation Bond accretion and other		-	-	-	-	-
Restricted contributions		-	-	-	-	-
Pension and other defined benefit plan adjustments		-	-	-	-	-
Increase/(Decrease) in cash due to change in:						
Patient accounts receivable, net		1,524	(11,149)	(5,686)	(5,800)	(5,916)
Other receivables, net		(2,079)	(2,183)	(2,293)	(2,407)	(2,528)
Inventories & prepaid expenses		2,266	(2,832)	(1,612)	(1,653)	(1,694)
Net deferred financing, acquisition costs & other charges		1,449	1,376	1,307	1,242	1,180
Other assets		(1,607)	(1,655)	(1,705)	(1,756)	(1,809)
Current portion of debt & liabilities		-	-	-	-	-
Accounts payable & accrued expenses		(2,100)	6,517	5,485	5,618	5,755
Estimated third-party payor settlements		369	377	384	392	400
Other long-term liabilities		1,633	1,665	1,699	1,733	1,767
Total adjustments		**127,962**	**118,480**	**124,407**	**125,241**	**126,627**
Net cash provided by operating activities		**137,057**	**161,504**	**170,672**	**174,005**	**177,166**
Cash flows from investing activities:						
Purchases of property, plant, and equipment		(125,000)	(131,250)	(137,813)	(144,703)	(151,938)
Acquisitions, net of cash acquired		-	-	-	-	-
Non-operating gains, net		23,099	23,561	24,032	24,512	25,003
Purchases of held-to-maturity securities		(23,099)	(23,561)	(24,032)	(24,512)	(25,003)
Net distribution from JV's and unconsolidated affiliates		-	-	-	-	-
Proceeds from sale of plant, property, and equipment		-	-	-	-	-
Net cash used in investing activities		**(125,000)**	**(131,250)**	**(137,813)**	**(144,703)**	**(151,938)**
Cash flows from financing activities:						
Payments on LT debt and liabilities, including escrow deposits		(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Payment of acquisition and financing costs		-	-	-	-	-
Proceeds from issuance of LT debt & other financings		-	-	-	-	-
Net amounts received on interest rate swaps		-	-	-	-	-
Restricted contributions received		-	-	-	-	-
Net cash used by financing activities		**(40,643)**	**(39,559)**	**(38,504)**	**(37,477)**	**(36,478)**
Net increase/(decrease) in cash and cash equivalents		(28,585)	(9,305)	(5,644)	(8,175)	(11,250)
Cash and cash equivalents at beginning of year		128,580	99,994	90,690	85,045	76,870
Cash and cash equivalents at end of year		**$ 99,994**	**$ 90,690**	**$ 85,045**	**$ 76,870**	**$ 65,621**

Income Statement - NewCo with Preliminary Efficiency Estimates	Actuals			Forecasted				
$'000s	FYE 6/13	FYE 6/14	FYE 6/15	Year 1	Year 2	Year 3	Year 4	Year 5
Net patient service revenue ("NPSR")	**$ 1,670,727**	**$ 1,671,050**	**$ 1,813,472**	**$ 1,812,747**	**$ 1,886,737**	**$ 1,924,471**	**$ 1,962,961**	**$ 2,002,220**
Other revenues:								
Other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total other revenues	**120,585**	**102,581**	**90,756**	**90,756**	**90,756**	**90,756**	**90,756**	**90,756**
Total revenue, gains, & support	**1,791,312**	**1,773,631**	**1,904,228**	**1,903,502**	**1,977,492**	**2,015,227**	**2,053,716**	**2,092,976**
Expenses:								
Salaries, wages, & benefits	881,530	865,989	925,061	936,615	938,313	941,691	935,264	946,416
Medical supplies & drugs	325,559	330,375	344,718	346,269	337,871	340,229	341,842	344,601
Purchased services	183,607	189,280	196,037	201,918	201,785	205,929	209,434	214,233
Interest & taxes	63,495	62,742	61,453	59,338	57,756	55,972	53,882	52,353
Depreciation & amortization	130,666	121,237	127,336	126,507	130,650	142,843	157,111	165,204
Maintenance & utilities	53,687	54,030	56,561	58,258	58,898	60,236	61,363	62,917
Lease & rental	17,892	15,506	15,435	15,821	16,216	16,558	16,820	17,228
Other	107,995	122,584	143,924	149,681	141,334	143,766	146,245	148,940
Total expenses & losses	**1,764,431**	**1,761,743**	**1,870,524**	**1,894,407**	**1,882,824**	**1,907,224**	**1,921,961**	**1,951,892**
Income from operations	**26,881**	**11,888**	**33,704**	**9,095**	**94,669**	**108,003**	**131,755**	**141,083**
Non-operating gains:								
Investment income	60,296	65,452	4,883	23,099	23,561	24,032	24,512	25,003
Derivative valuation adjustments	9,474	4,526	19,093	-	-	-	-	-
Loss on refinancing	-	(5,755)	(1,389)	-	-	-	-	-
Gain on revaluation of equity method investment	-	14,744	-	-	-	-	-	-
Non-operating gains, net	**69,770**	**78,967**	**22,587**	**23,099**	**23,561**	**24,032**	**24,512**	**25,003**
Revenues & gains in excess of expenses & losses	**96,651**	**90,855**	**56,291**	**32,194**	**118,229**	**132,035**	**156,267**	**166,086**
Other non-operating items:								
Discontinued operations	(4,484)	(26,639)	(2,720)	-	-	-	-	-
Income attributable to non-controlling interest	(7,728)	(9,826)	(15,046)	(14,483)	(14,999)	(15,054)	(15,099)	(15,133)
Total other non-operating operations	**(12,212)**	**(36,465)**	**(17,765)**	**(14,483)**	**(14,999)**	**(15,054)**	**(15,099)**	**(15,133)**
Revenues & gains in excess of expenses & losses attributable to	**$ 84,439**	**$ 54,390**	**$ 38,526**	**$ 17,711**	**$ 103,230**	**$ 116,980**	**$ 141,168**	**$ 150,953**
Uses expense related to COPA, excluding D&A expense	-	-	-	-	(10,750)	(27,250)	(43,500)	(49,000)
Net income, including COPA uses attributable to NewCo.	**$ 84,439**	**$ 54,390**	**$ 38,526**	**$ 17,711**	**$ 92,480**	**$ 89,730**	**$ 97,668**	**$ 101,953**

Balance Sheet - NewCo with Preliminary Efficiency Estimates	Actuals			Forecasted				
$'000s	6/30/13	6/30/14	6/30/15	Year 1	Year 2	Year 3	Year 4	Year 5
Current assets:								
Cash & cash equivalents	$ 130,860	$ 89,859	$ 128,580	$ 99,994	$ 115,197	$ 91,247	$ 93,168	$ 135,397
Current portion of investments	25,447	28,262	22,904	22,904	22,904	22,904	22,904	22,904
Patient accounts receivable, net	271,216	278,583	274,678	273,154	284,303	289,989	295,789	301,704
Other receivables, net	51,463	60,187	41,588	43,667	45,851	48,143	50,551	53,078
Inventories & prepaid expenses	58,383	59,859	63,930	61,664	60,169	60,589	60,876	61,367
Total current assets	**537,370**	**516,750**	**531,680**	**501,384**	**528,424**	**512,873**	**523,287**	**574,452**
Other non-current assets:								
Long-term investments	1,037,563	1,124,957	1,154,927	1,178,026	1,201,586	1,225,618	1,250,131	1,275,133
Property, plant, & equipment, net	1,359,023	1,374,010	1,331,657	1,330,150	1,360,750	1,420,720	1,468,311	1,480,046
Goodwill	169,487	208,262	208,179	208,179	208,179	208,179	208,179	208,179
Net deferred financing, acquisition costs & other charges	33,658	30,067	28,972	27,523	26,147	24,840	23,598	22,418
Other assets	47,091	48,870	53,567	55,174	56,830	58,534	60,290	62,099
Total other non-current assets	**2,646,822**	**2,786,166**	**2,777,303**	**2,799,052**	**2,853,492**	**2,937,891**	**3,010,509**	**3,047,875**
Total assets	**3,184,192**	**3,302,916**	**3,308,983**	**3,300,436**	**3,381,916**	**3,450,764**	**3,533,796**	**3,622,327**
Current liabilities:								
Current portion of debt & liabilities	75,323	73,791	84,731	84,731	84,731	84,731	84,731	84,731
Accounts payable & accrued expenses	242,267	261,554	270,782	268,682	275,199	280,683	286,301	292,056
Estimated third-party payor settlements	33,932	18,888	18,471	18,841	19,217	19,602	19,994	20,394
Total current liabilities	**351,523**	**354,233**	**373,985**	**372,254**	**379,148**	**385,017**	**391,027**	**397,181**
Non-current liabilities:								
Long-term debt & liabilities	1,566,294	1,565,512	1,524,098	1,483,455	1,443,897	1,405,393	1,367,915	1,331,438
Retention bonus liability	-	-	-	-	5,000	-	-	-
Other long-term liabilities	78,447	99,400	81,633	83,265	84,931	86,629	88,362	90,129
Total non-current liabilities	**1,644,740**	**1,664,912**	**1,605,731**	**1,566,721**	**1,533,827**	**1,492,022**	**1,456,277**	**1,421,567**
Total liabilities	**1,996,263**	**2,019,145**	**1,979,715**	**1,938,975**	**1,912,975**	**1,877,038**	**1,847,304**	**1,818,748**
Net assets:								
Unrestricted	994,348	1,080,586	1,112,232	1,129,943	1,222,424	1,312,154	1,409,822	1,511,775
Temporarily restricted	19,703	20,418	20,508	20,508	20,508	20,508	20,508	20,508
Permanently restricted	1,438	1,446	1,450	1,450	1,450	1,450	1,450	1,450
Noncontrolling interests	172,439	181,321	195,078	209,560	224,559	239,614	254,713	269,846
Total net assets	**1,187,929**	**1,283,771**	**1,329,268**	**1,361,462**	**1,468,941**	**1,573,725**	**1,686,493**	**1,803,579**
Total liabilities and net assets	**$3,184,192**	**$3,302,916**	**$3,308,983**	**$ 3,300,436**	**$ 3,381,916**	**$ 3,450,764**	**$ 3,533,796**	**$ 3,622,327**

Statement of Cash Flows - NewCo with Preliminary Estimated Efficiencies						
		Forecasted				
$'000s	Scenario	Year 1	Year 2	Year 3	Year 4	Year 5
Cash flows from operating activities:						
Income from operations		$ 9,095	$ 94,669	$ 108,003	$ 131,755	$ 141,083
Uses expense related to COPA, excluding D&A expense		-	(10,750)	(27,250)	(43,500)	(49,000)
		9,095	**83,919**	**80,753**	**88,255**	**92,083**
Adjustments to reconcile change in net assets to net cash provided by operating activities:						
Depreciation and amortization		126,507	130,650	142,843	157,111	165,204
Loss on extinguishment of debt		-	-	-	-	-
Change in estimated fair value of derivatives		-	-	-	-	-
Equity in net income of JVs, net		-	-	-	-	-
Loss/(Gain) on disposal of assets		-	-	-	-	-
Capital Appreciation Bond accretion and other		-	-	-	-	-
Restricted contributions		-	-	-	-	-
Pension and other defined benefit plan adjustments		-	-	-	-	-
Increase/(Decrease) in cash due to change in:						
Patient accounts receivable, net		1,524	(11,149)	(5,686)	(5,800)	(5,916)
Other receivables, net		(2,079)	(2,183)	(2,293)	(2,407)	(2,528)
Inventories & prepaid expenses		2,266	1,496	(420)	(287)	(491)
Net deferred financing, acquisition costs & other charges		1,449	1,376	1,307	1,242	1,180
Other assets		(1,607)	(1,655)	(1,705)	(1,756)	(1,809)
Current portion of debt & liabilities		-	-	-	-	-
Accounts payable & accrued expenses		(2,100)	6,517	5,485	5,618	5,755
Estimated third-party payor settlements		369	377	384	392	400
Retention bonus liability		-	5,000	(5,000)	-	-
Other long-term liabilities		1,633	1,665	1,699	1,733	1,767
Total adjustments		**127,962**	**132,093**	**136,614**	**155,846**	**163,562**
Net cash provided by operating activities		**137,057**	**216,011**	**217,367**	**244,101**	**255,646**
Cash flows from investing activities:						
Purchases of property, plant, and equipment		(125,000)	(161,250)	(202,813)	(204,703)	(176,938)
Acquisitions, net of cash acquired		-	-	-	-	-
Non-operating gains, net		23,099	23,561	24,032	24,512	25,003
Purchases of held-to-maturity securities		(23,099)	(23,561)	(24,032)	(24,512)	(25,003)
Net distribution from JV's and unconsolidated affiliates		-	-	-	-	-
Proceeds from sale of plant, property, and equipment		-	-	-	-	-
Net cash used in investing activities		**(125,000)**	**(161,250)**	**(202,813)**	**(204,703)**	**(176,938)**
Cash flows from financing activities:						
Payments on LT debt and liabilities, including escrow deposits		(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Payment of acquisition and financing costs		-	-	-	-	-
Proceeds from issuance of LT debt & other financings		-	-	-	-	-
Income attributable to non-controlling interest		-	-	-	-	-
Net amounts received on interest rate swaps		-	-	-	-	-
Restricted contributions received		-	-	-	-	-
Net cash used by financing activities		**(40,643)**	**(39,559)**	**(38,504)**	**(37,477)**	**(36,478)**
Net increase/(decrease) in cash and cash equivalents		(28,585)	15,202	(23,949)	1,920	42,230
Cash and cash equivalents at beginning of year		128,580	99,994	115,197	91,247	93,168
Cash and cash equivalents at end of year		**$ 99,994**	**$ 115,197**	**$ 91,247**	**$ 93,168**	**$ 135,397**

Exhibit 11.9

Mountain States Insurance Contracts and Payer Agreements

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

Wellmont Insurance Contracts and Payer Agreements

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.

Exhibit 11.12

Information regarding future and existing business plans of Wellmont is considered competitively sensitive information under federal antitrust laws.

Exhibit 11.13

New Health System Alignment Policy

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.

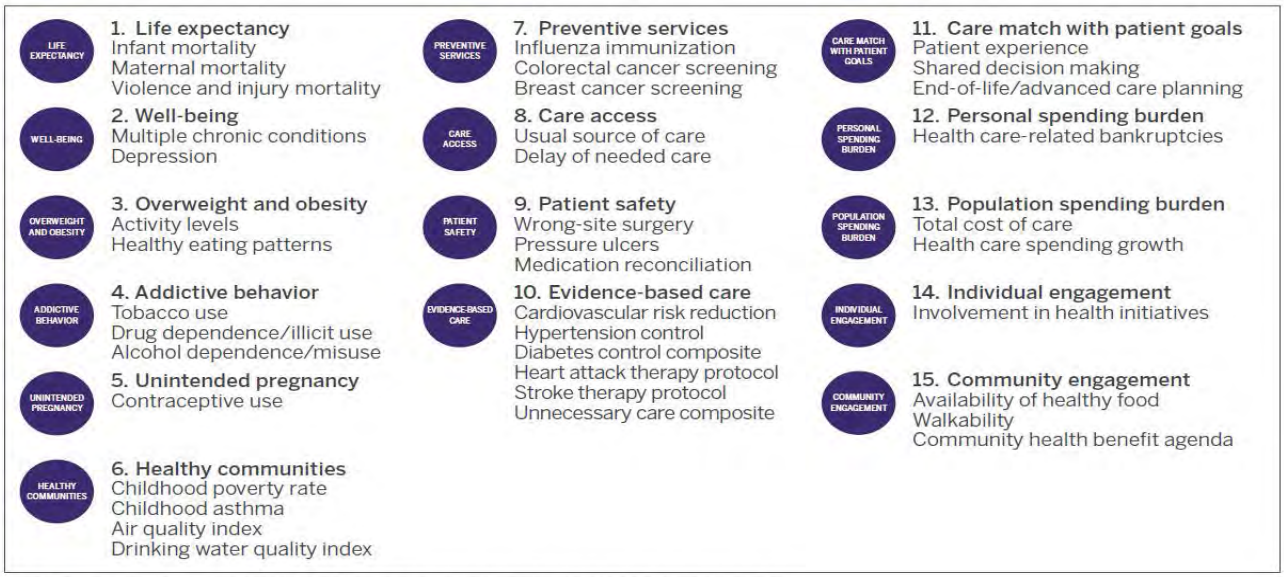
Exhibit 11.14

Institute of Medicine Vital Signs Core Measures

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**

Revised Plan of Separation
between
Wellmont Health System
and
Mountain States Health Alliance

Pursuant to Grant of Certificate of Public Advantage
By the Tennessee Commissioner of Health

This Revised Plan of Separation ("the Revised Plan") is prepared as part of the application for Certificate of Public Advantage ("COPA") submitted jointly by Wellmont Health System and Mountain States Health Alliance (collectively "the Parties") to the Tennessee Department of Health ("the Department"). The Revised Plan is intended to set out the process by which the Parties would effect an orderly separation of the new, integrated health system to be created under the COPA (the "New Health System") in the event that the Department determines that it is necessary to terminate the COPA previously granted to the Parties, as set forth in T.C.A. section 68-11-1303(g).

1. Overview. The purpose of this outline is to comply with Tenn. Comp. Rules & Regulations 1200-38-01-.02(2)(a)(17). The Revised Plan will be described in two scenarios: the "Short-Term Period" (0 to 18 months) and the "Long-Term Period" (after 18 months).

2. Short-Term Period Plan of Separation. (0 to 18 months post-closing)

   A. Overview. Re-establish a competitive dynamic by returning assets and operations to the control of the contributing party.

   B. Assets Held Separate. Mountain States and Wellmont will not, during the Short-Term Period, transfer to the other, or to the New Health System, any Material Operating Assets held by either Mountain States or Wellmont prior to the affiliation. For purposes of this commitment, "Material Operating Assets" shall mean those assets that exceed 10% of the New Health System's total assets or roughly $300 million. Assets used in providing support services to Mountain States and Wellmont may be transferred as appropriate to effect the integration and achieve cost savings and performance improvement.

   C. The Process. Upon written notice from the Department that the COPA has been terminated, the following would occur:

      (1) Preservation of Business. The New Health System will take all actions necessary to maintain the independent viability and competitiveness of Mountain States and Wellmont pending separation.

      (2) Governance. The New Health System's Board of Directors will oversee the plan of separation to insure that the plan is successfully implemented, minimizing to the extent possible disputes between the separating entities and

disruptions in operations. Upon implementation of the plan of separation, the New Health System will be removed as member of Mountain States and Wellmont. Mountain States and Wellmont will return as the parent corporations of the pre-combination entities:

a) Mountain States. Mountain States directors will resign from the Wellmont Board and the New Health System Board. Mountain States directors will appoint additional directors to the Mountain States Board.

b) Wellmont. Wellmont directors will resign from the Mountain States Board and the New Health System Board. Wellmont directors will appoint additional directors to the Wellmont Board.

(3) Management.

a) The Executive Chair/President of the New Health System will be named the Chief Executive Officer of Mountain States.

b) The Chief Executive Officer of the New Health System will be named the Chief Executive Officer of Wellmont.

c) Mountain States and Wellmont will appoint other executive officers of the respective corporations pursuant to established corporate procedures.

d) Clinical Managers will be assigned to the Mountain States/Wellmont Clinical Site that is the Manager's principal place of service.

(4) Financial. Mountain States and Wellmont will become separate financial enterprises.

a) Debt. Any debt issued by the New Health System will be allocated to Mountain States and Wellmont based upon the proportion of pre-merger debt that each brought to the merger, except that if the proceeds of any debt issued by the New Health System have been used to benefit a facility or facilities (e.g, debt proceeds used to expand physical plant), such debt will be allocated to the entity which receives that facility in the separation.

b) Reserves. The cash and marketable securities of the New Health System will be separated between Mountain States and Wellmont in proportion to the original contribution at closing.

(5) Employees. The New Health System employees will be assigned to their principal place of business. Clinical employees will be assigned to the

Mountain States/Wellmont site that is the employee's principal place of service.

(6) Employee Benefits. To the extent employee benefit plans have been combined, a plan of separation addressing employee benefits will be submitted. Each of Mountain States and Wellmont will be free to change or modify plans under separation. Mountain States and Wellmont will provide all legacy employees with credit for their New Health System service.

(7) Clinical Services. During the Short-Term Period, the New Health System expects the consolidation of any significant clinical services to be limited. To the extent clinical services are combined, a plan of separation addressing clinical services, including a transition services agreement, will be submitted to the Tennessee Department of Health for information prior to such combination.

(8) Information Technology. During the Short-Term Period, the New Health System will develop a combined approach to information technology. While planning and implementation are expected to begin, it is not anticipated that the Common Clinical IT Platform will be fully implemented in the Short-Term Period. Mountain States/Wellmont will each establish separate information technology services as part of the plan of separation. Transition services agreements will be utilized to assure no interruption in operations for Mountain States or Wellmont post-separation.

(9) Payers. During the Short-Term Period, the New Health System expects to negotiate payer agreements consistent with the terms and provisions of the COPA. In the event of any separation of the New Health System during the Short-Term Period, both Mountain States and Wellmont will honor the provisions of the New Health System payer agreements for the balance of any base term (without renewals). If any payer wishes to modify or replace its New Health System payer agreement, Mountain States and Wellmont will negotiate in good faith to reach a mutually acceptable modified or new agreement. All future payer agreements will be negotiated separately by Mountain States and Wellmont.

(10) Physicians. During the Short-Term Period, the New Health System expects to plan, but not execute, a combination of its physician enterprises. To the extent any physician services are combined, a plan of separation addressing physician services, including actions to return physician and other clinic employees to the Mountain States or Wellmont entity that was his or her employer at the closing, will be submitted to the Tennessee Department of Health for information prior to action. Hospital-based physician contracts, such as radiology, pathology, anesthesia, hospitalists,

and emergency medicine shall be assigned to the site of service. Mountain States and Wellmont shall honor the physician contracts for the remainder of the base terms (without renewals).

(11) Dissolution. Once Mountain States and Wellmont no longer require support services from the New Health System, the Board of Directors of the New Health System will follow the procedures for voluntary dissolution of the New Health System as provided by Tennessee law.

3. Long-Term Period Plan of Separation. (after 18 months post-closing)

A. Overview. The Long-Term Period plan of separation would be implemented if the Department terminates the COPA after determining that the benefits of the merger no longer outweigh the disadvantages by clear and convincing evidence. Due to the difficulty of predicting the health care environment in the long term, the Long-Term Period plan of separation of necessity is a description of a process for deciding how to separate the assets and operations of the New Health System.

B. The Process:

(1) Upon receipt of written notice from the Department that the COPA has been terminated, the New Health System will retain a qualified consultant ("the Consultant").

(2) The Consultant will assist the New Health System in complying with the written notice that the COPA has been terminated by analyzing competitive conditions in the markets subject to the Department's written notice and identifying the specific steps necessary to return the subject markets to a competitive state.

(3) The New Health System will submit a plan of separation to the Department (the "Proposed Plan). The Proposed Plan will address each of the substantive elements required of a Short-Term Period plan of separation and will be accompanied by a written report from the Consultant concerning the suitability of the Proposed Plan in addressing the competitive deficiencies that resulted in the termination of the COPA.

(4) The Proposed Plan shall be submitted within 180 days of receipt of written notice from the Department that the COPA has been terminated. The Proposed Plan shall include a timetable for action which shall be approved by the Department.

C. Upon the Department's approval of the Proposed Plan (or of any plan that contains revisions thereto) (the "Final Plan"), the New Health System will implement the Final Plan within the timetable prescribed in the Final Plan.

D. The Final Plan will provide that the Department may require that an independent third-party health care expert serve as a monitor ("the Monitor") to oversee the

process of implementing the Final Plan. The New Health System will pay the fees and expenses of the Monitor.

4. Non-Exclusive Plan. To the extent the Parties or the New Health System reasonably determines (based upon the current facts and circumstances) that a competitive dynamic may be restored in another, more efficient or effective means, the Parties or the New Health System may submit a new plan of separation different from the pre-submitted plan. In such event, the amended plan of separation must receive the Department's approval prior to its implementation.

5. Annual Update. Department regulations provide that the plan of separation be updated annually. The annual update will address each of the following elements as appropriate and possible in light of the then existing facts and circumstances: (a) Governance, (b) Management, (c) Financial Separation, (d) Employees, (e) Employee Benefits, (f) Clinical Services, (g) Information Technology, (h) Payers, and (i) Physicians.

RESPONSES TO QUESTIONS

SUBMITTED NOVEMBER 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

Ballad Health[1]
Overview of Approach

Executive Summary: In response to the Tennessee Department of Health's Request for Information dated November 22, 2016 (the "Request for Information"), we provide an overview of Ballad Health's transformation from two individual and traditional health care delivery systems to a fully integrated and aligned health care delivery system responsible for providing value-driven community health improvement to the communities served by the combined system. This overview is intended to inform the series of responses that will be submitted addressing each individual request identified in the Request for Information.

Ballad Health has a unique opportunity to deliver unprecedented value and public advantage by realigning the two existing health systems of the region into a single integrated delivery system of healthcare providers to provide a coordinated, continuum of services to the community. Ballad Health will be accountable, both clinically and fiscally, on its own and as required with partners, for the clinical outcomes and health status of the population it serves, and will put systems in place to manage and improve them.

In addition to its transformation to a single and fully integrated delivery system, Ballad will reach beyond the clinical settings to expand its focus from medical care delivery alone to broader community health with a substantial focus on prevention. The combined impact of fully integrated delivery system and increased focus on prevention and community health will lead to a reduction in the development, prevalence, and progression of diseases, creating a more direct path to improved health and health outcomes. Though the specific pace of improvement toward these outcomes will be difficult to anticipate because of the variety of factors impacting them in a large, diverse population, measures should be identified for tracking and continual improvement of specific efforts designed to derive the desired outcomes. Focus on intermediate outcomes and effective implementation of best practice prevention and intervention efforts will allow research and learning to occur in collaboration with Ballad Health, state and local public health, academic partners, and community partners. Central to this is the development of annual plans which support the strategic, long-term Community Health Improvement Plan. Fulfillment of the requirements set forth in the annual plan will be central to ongoing, active supervision and evaluation of COPA progress.

Evolution to this broader model entails an effective interface between the healthcare delivery system and its internal partners with all of the key attributes of integrated delivery system, clinical protocols, infrastructure and facilities and population health medicine and largely external partners focused primarily on community health improvement.[2] Ballad Health will engage directly as an integrated

[1] Since filing the Application for a Certificate of Public Advantage in February, 2016, the Parties have announced "Ballad Health" as the name the New Health System will adopt if the merger is approved and the Certificate of Public Advantage is issued. The responses to the Tennessee Department of Health's Request for Information dated November 22, 2016, may use "Ballad Health" and the "New Health System" interchangeably to refer to the merged health system.

[2] For purposes of this response, we define "population health medicine" as the specific activities of the medical care system that, by themselves or in collaboration with partners, promote population health beyond the goals of care of the individuals treated. We define "community health improvement" to mean efforts to improve health outcomes in targeted populations by addressing priority health needs and social determinants of health with

delivery system to align incentives around the Triple Aim goals of the healthcare delivery system and to align with insurers and other stakeholders to seek to reduce costs, improve outcomes, and enhance patient access and experience across all of the area populations it serves. Ballad Health will create a new Department of Population Health Improvement, staffed with internal resource personnel who will work to coordinate and connect internal and external systems to lead, convene, facilitate, influence, and implement change management plans to realize this transformation.

We have included a timeline overview which will guide the initial development of the Department and the Accountable Care Community, which will be the primary vehicle for the coordination of activities around community health improvement. Additionally, we have addressed the priorities and funding for these components, the sustainability of these efforts, and an explanation for why these two initiatives are specific to the merger.

I. Overview of Approach.

Ballad Health seeks to redefine the current approach to traditional health care delivery in order to become an integrated delivery system that serves as the basis for a broader value-driven community health improvement organization. This involves two important and highly complementary aspects:

1) Ballad Health will transform the medical care system in the region from two traditional healthcare systems to a fully integrated delivery system with the ability to take on greater risk and to provide significantly enhanced value for its communities. Enhanced value includes coordination across the healthcare delivery system on best location of care, care closer to home, and approaches that rely on enhanced IT, physician leadership, and clinical alignment around health, outcomes, access and quality. This will require an ongoing shift of clinical and leadership focus from the volume of services provided to the patient outcomes achieved, as well as supporting infrastructure and new financial commitments by Ballad Health. In place of the existing fragmented system this fully integrated healthcare delivery system will develop systems of care and embedded protocols through clinically aligned networks and common, clinically integrated electronic medical record system to serve patients with improved results across diverse locations, and enable independent physicians and other providers not only to actively participate, but to benefit from Ballad's investments and infrastructure.[3] In addition, the newly developed leadership, clinical council, investments, infrastructure and quality initiatives will further facilitate enhanced partnering with payers on risk-based and value-based initiatives that serve the common interests of improved outcomes and savings.

2) Ballad Health will also establish an Accountable Care Community to reach beyond the traditional healthcare delivery system to impact community health improvement with our partners. Ballad

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evidence-based initiatives resulting in a positive change in health outcomes." Of necessity, Ballad Health as a healthcare delivery system, will be intimately involved in population health medicine, and also engaged in community health improvement activities, for example, by its engagement with prevention efforts with its primary care physicians.

[3] We note that Ballad Health will take on the financial commitments and investments in the healthcare delivery system, and motivate and make available the benefits of platforms and other infrastructure to independent physicians and other providers to improve their ability to deliver higher value care to residents.

Health will establish a new Department of Population Health to bridge the healthcare delivery and clinical alignment efforts for the health system and the community health improvement efforts being expanded on through the Accountable Care Community. This component will impact the population as a whole.

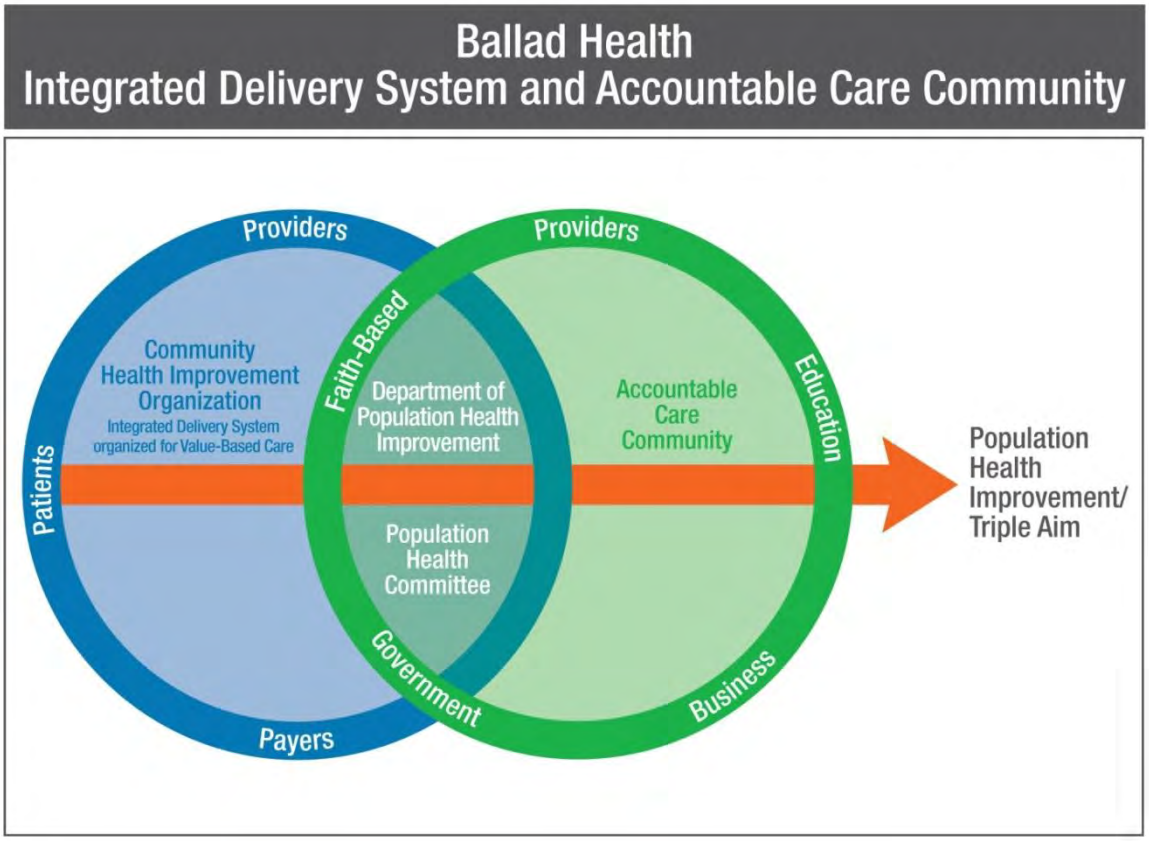
Through this combined strategy of integrated care delivery and community health improvement, Ballad Health will transcend the traditional role of health care provider to become a community health improvement organization. This dual approach has the best chance of achieving Triple Aim objectives both through the healthcare delivery system and through community-based initiatives, and would establish one of the first Accountable Care Community models in the state of Tennessee. Our strategy captures a key community value-proposition of Ballad Health.

The move towards more fully integrated healthcare delivery systems with aligned incentives for value-based care is an attempt to address an unsustainable regional and national health care model with unpredictable and untenable rate increases for employers and the subs medical and productivity costs plaguing employers and their employees. While there is much uncertainty about the direction of health care reform in the current political environment, particularly the fate of the Affordable Care Act, experts generally agree that value-based care and risk-based payment models are here to stay.[4] Most importantly, providers, employers, insurers, and communities are unlikely to change the imperative to address critical health, access, cost and quality needs at the local level – the level generally recognized as the point at which transformative change can most readily occur. We believe that value-based care is not a destination but a path, and Ballad Health's course must include as a priority the alignment of incentives and investments in a local delivery system that meets the significant population health needs of Tennessee and Virginia.

As Ballad Health prepares to transform two individual and traditional health care delivery systems into a fully integrated and aligned health care delivery system, it must embrace a strategy built upon locally-driven and value-driven community health improvement.[5]

[4] *See* Elizabeth Whitman, *Will value-based payment initiatives continue under Trump?*, MODERN HEALTHCARE (November 11, 2016) (*stating* "President-elect Donald Trump's promise to dismantle the Affordable Care Act is unlikely to also undo widespread efforts to nudge the U.S. healthcare system toward value-based payment, including experiments devised by the ACA-funded Center for Medicare & Medicaid Innovation."), *available at* http://www.modernhealthcare.com/article/20161111/MAGAZINE/161109907.

[5] *See* Bruce Hamory & Dan Shellenbarger, *Value-Based Care Under President-Elect Trump? Here to Stay* (November, 2016) (*stating* "No matter what happens with the ACA, now is not the time for providers to ease off their transformation efforts."), *available at* http://health.oliverwyman.com/maximize-value/2016/11/value-based_careund.html.



II. Key Organizational Components Defined.

Several important organizational components are referenced in this overview, each of which contributes uniquely to the goal of achieving the broad goal of community health improvement:

Integrated Delivery System: Ballad Health intends to transform the two traditional delivery systems into a single, fully integrated healthcare delivery system of hospitals, outpatient facilities, physicians, and other providers in the Ballad Health system aligned to meet the needs of the full population of the Geographic Service Area in the most effective and appropriate location of care with the requisite investments and financial commitments. Ballad Health will be accountable, both clinically and fiscally, for the clinical outcomes and health status of the population it serves, and will put systems in place to manage and improve them. The healthcare delivery system will be the basis by which Ballad Health will work with payers to align incentives and initiatives; independent physicians and providers will be able to access the system and obtain its benefits.

Accountable Care Community: The Accountable Care Community is an organization that Ballad Health will establish and lead to meaningfully and measurably impact the health of the whole population with our partners. This model extends the benefits of the critical transformation within the healthcare delivery system into specific partnerships and affiliations in the immediate community better to address specific population health needs. The goal will be to create a model of self-sustainability and broad-based community ownership of these external initiatives. The Accountable Care Community will be essential to a successful fulfillment of the Community Health Improvement Plan and regionally coordinated and scaled efforts around common objectives. We

envision that state or regional Department of Health leaders will serve in key roles for the Accountable Care Community.

Department of Population Health Improvement: The Ballad Health Department of Population Health Improvement will be created and led by a senior executive who reports directly to the President and Executive Chair of Ballad Health. This department will be instrumental in the development of the Accountable Care Community as well as serve as the primary liaison to all regulatory agencies and to the Ballad Health Board Committee on Population Health and Social Responsibility. The Department of Population Health Improvement will be staffed with key leaders whose roles will ensure that all relevant COPA commitments are fulfilled and supported by strong planning, implementation, evaluation, and improvement efforts driven both directly by Ballad Health and/or through the Accountable Care Community.[6] Funding for community health improvement efforts will be managed through this Department.

Population Health and Social Responsibility Committee of the Board: This standing committee of the Ballad Health Board of Directors will include regional and multi-sector representation and will be responsible for oversight and compliance with all COPA commitments and reporting requirements. It will also be responsible for governing the alignment of COPA Funding, Social Responsibility strategies, and COPA efforts to produce health improvement in the community. Members of the Committee will include Ballad Health directors and other community members appointed by the Ballad Health Board. Leaders from this committee will also serve on the Accountable Care Community board.

Physician Clinical Council: Ballad Health will form a Physician Clinical Council which will be instrumental in guiding Ballad's work to achieve the Triple Aim and creating a shared culture of health care quality, transparency, and population health improvement. It is envisioned that the Physician Clinical Council will be independent of the Accountable Care Community, and that its efforts will focus on key aspects of clinical integration and development of the integrated delivery system. Led by the Quality Committee of the Ballad Health Board and Ballad Health's Chief Medical Officer, the Physician Clinical Council will be appointed jointly by the medical staffs of Ballad Health hospitals and by the Ballad Health Board of Directors. This will facilitate the connection back to each hospital's medical staff and to community-based physicians in order to influence physician practice patterns and to receive and incorporate best practices across the system. It is anticipated that the Ballad Health Chief Medical Officer and other members of the Physician Clinical Council will serve in the Accountable Care Community leadership and on the Population Health and Social Responsibility Committee of the Board to further these mutually supportive efforts.

III. The Integrated Delivery System.

The merger provides a unique opportunity to transform two independent health care delivery systems with duplicative services and equipment into one fully integrated healthcare delivery system. The integrated delivery system will operate more effectively and efficiently by allocating resources to the highest priority needs of the system and the community health, realigning facilities and clinical services to best purposes and supporting coordination of care and efforts to shift and support care delivery at the most cost effective and best location for the patient. The merged, integrated system will be more

[6] It is envisioned that several COPA commitments involving population health, health metrics, and improvements will be the primary responsibility of this Department.

readily able to take on and manage risk for the populations it serves because synergies can be reinvested in the infrastructure and human resources needed to succeed with population health. The savings from the synergies will be reinvested in the implementation of the Common Clinical IT Platform, the alignment of clinical protocols, and the implementation of new data analytics and case management programs. Ballad Health will now have the ability to work with the complete population of each payer and the community to achieve and share in the cost savings and improved outcomes provided by its commitments and investments in healthcare delivery. Ballad Health will be fully committed, and accountable, for achieving the benefits made possible by the merger and committed to under the COPA, and will work to align incentives with payers, the State, other providers, and the community to achieve improved access, lower costs of care, and improve outcomes in a way that yields substantial savings for residents, employers, insurers, and the State. As healthcare transformation experts have noted, there are huge opportunities for improving value through the development of integrated delivery systems.[7] Specifically, the elimination of fragmentation and duplication of care and to optimize the types of care delivered in each location.

A. Managing the Transformation to an Integrated Delivery System.

We will work internally to position Ballad Health for a smooth and effective transition to a value-based approach to health care delivery that includes enhanced pay-for-value and risk-based models of population health medicine, and most importantly for alignment of care delivery and location along with treatment in the most cost effective and high valued way. The essential pathways include greater alignment of both incentives and operations under a single physician-led council and overall leadership to use the resources available in the most effective way to address needs, improve outcomes, provide for greater financial stability and sustainability of care, and lead to the way to greater ability for enhanced risk-based approaches. This may also include the development of a clinically integrated network in partnership with the independent physician community. Under these risk-based, value-based payment models and other initiatives, Ballad Health will be incentivized for achieving cost and outcomes of care, and have incentives to keep people well. These plans are further outlined in responses relating to clinically aligned systems and the IT platform, as well as in the cultural alignment response.

B. Challenges and Strategies

We recognize that challenges will exist in the transformation from two individual and traditional health care delivery systems to a fully integrated and aligned health care delivery system.[8]

- Challenge: Achieving integrated care will require changing health-care culture and how clinicians think about care delivery.[9]
    - Strategy: Ballad Health acknowledges that a move to integrated care will require a cultural change. Ballad Health has specifically addressed its plans for cultural transformation in Response #7: The Cultural Alignment Plan.

[7] *See* Michael E. Porter & Thomas H. Lee, *The Strategy That Will Fix Health Care*, HARV. BUS. REV. (October 2013), *available at* https://hbr.org/2013/10/the-strategy-that-will-fix-health-care.

[8] *See* Kenneth W. Kizer, Professor at UC Davis Inst. for Population Health Improvement, Achieving integrated health care: Nine key lessons, Address to the International Integrated Care Conference (April 4, 2014), *summary available at* http://www.ucdmc.ucdavis.edu/publish/news/newsroom/8847.

[9] *See id*. (*stating* "Achieving integrated care first and foremost requires changing health-care culture and how clinicians think about care delivery.").

- Challenge: Strong and respected clinical leadership will be essential for achieving clinical integration.[10]
    - Strategy: Ballad Health recognizes that effective clinical leaders will be needed to promote and maintain focus on the vision of integrated care over the long term. Ballad health will establish a system-wide, physician-led Clinical Council in order to identify best practices that will be used to develop standardized clinical protocols and models for care across the New Health System. These standardized practices, models and protocols will help reduce error and overlap, shorten length of stay, reduce costs, and improve patient outcomes. Additional information about the Clinical Council is included in Response #8: The New Clinical System. Under any clinically integrated network that Ballad may form in partnership with independent physicians, governance would be primarily physician-driven.

- Challenge: Financial payment methods will need to be aligned with and support the desired outcomes of the integrated delivery system.[11]
    - Strategy: As Ballad Health transitions from a traditional health care delivery system to a combined and integrated healthcare delivery system and then on to a more fully developed value-driven community health improvement organization, it will work with commercial payers and participate in government payer programs to implement more value-based approaches to health care delivery that include pay-for-value and risk-based models of population health medicine. Any clinically integrated network which Ballad may form in partnership with independent physician groups will allow Ballad and these groups to align financial incentives to produce value in a manner not possible otherwise. Ballad Health's strategy to move increasingly towards value-based contracting and risk-based models is detailed in Response #2: The Insurance and Value Payment Transition.

- Challenge: Information management and administrative infrastructure will be needed to facilitate a culture of collaboration and continuous improvement.[12]
    - Strategy: The parties have committed to the adoption of a Common Clinical IT Platform to ensure that information needed to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. In addition, the parties have committed to meaningful participation in a region-wide health information exchange to promote coordination among community providers, including those providers not part of the New Health System. Both health systems also have developed process and quality improvement departments which focus on lean management principles for continuous improvement. These efforts will be unified and targeted. Ballad will also reorganize and expand its analytics capabilities under a new Analytics department, and is currently in process of developing a common analytics Request for Proposal under pre-merger planning. Additional details about Ballad Health's plans to use information technology to facilitate

[10] *See id*. (*stating* "Strong and respected clinical leadership is essential for achieving clinical integration.").
[11] *See id*. (*stating* "[R]emoving financial disincentives to providing integrated care may be as important, or even more important, than providing positive financial incentives.").
[12] *See id*. (*stating* "Achieving integrated care requires an enabling information management and administrative infrastructure, but to be optimally effective these must be embedded in a culture of collaboration and continuous improvement.").

a culture of collaboration and continuous improvement are addressed in Response #9: The IT Strategy.

- Challenge: Clinical care delivery assets will need to be significantly restructured to provide integrated care.[13]
    - Strategy: As the Parties have outlined in the Application, Ballad Health will adopt a comprehensive Alignment Policy that sets forth a rigorous, systematic method for evaluating the potential merits and adverse effects related to access, quality and service for patients when making decisions regarding changes that may leave a community without services traditionally provided in that immediate area. This Policy will allow the new health system to ensure that the care delivery decisions of the New Health System are aligned with the interests of the community. In addition, the Ballad strategic plan will place priority focus on the need for new and expanded population medicine resources such as analytics, case management, health coaching, new modes of access such as telemedicine and expanded clinical call centers, the clinically integrated network structure and effective use of a common EHR and HIE system. Additional details about this process are addressed in Response #3: The Structure for the Future.

- Challenge: Communicating the change process will require a strategic communications plan.[14]
    - Strategy: The Parties will establish a strategic communications and organizational development plan to affect the change management process. Physicians and nurses will be prepared to communicate the plan's key messages because they are generally viewed as the most credible messengers to patients.[15] Ballad Health has specifically addressed its plans for communicating the cultural transformation in Response #7: The Cultural Alignment Plan.

IV. The Accountable Care Community.

The second component of the move to a value-driven community health improvement organization will be the establishment of an Accountable Care Community that will allow Ballad Health to work with its partners to more meaningfully and measurably impact the health of the whole population. This model extends the benefits of the critical transformation within the healthcare delivery system into specific partnerships and affiliations in the immediate community to address the agreed upon population health needs.

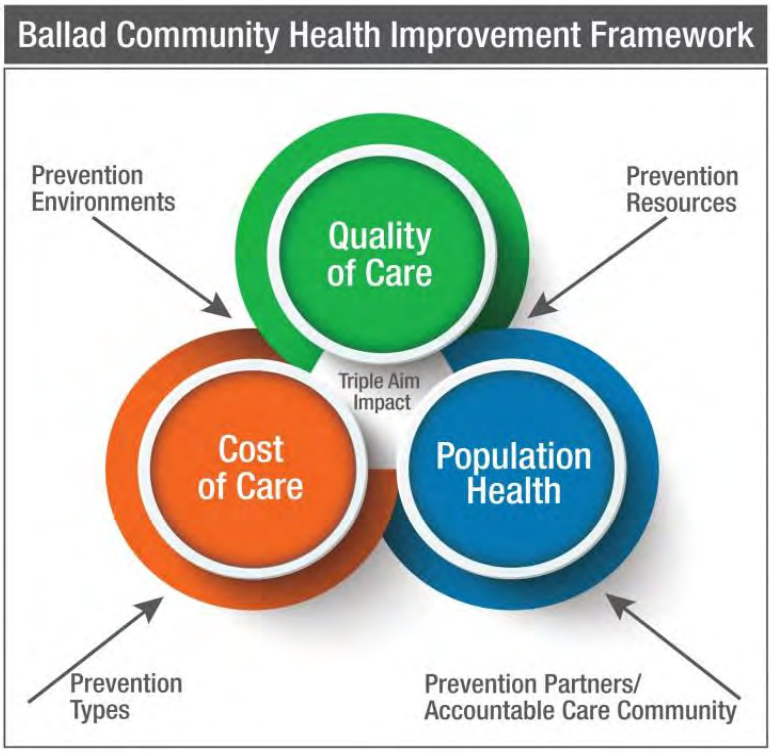
A. Establishment of the Accountable Care Community

An Accountable Care Community encompasses leadership and stakeholders not only from the medical care delivery system, but also from the public health system, employers, community stakeholders at the grassroots level, and community organizations whose work often encompasses the entire spectrum of

[13] *See id*. (*stating* "Clinical care delivery assets in most health-care organizations will need to be significantly restructured to provide integrated care.").
[14] *See id*. (*stating* "An essential but often overlooked element in achieving integrated care is a strategic communications plan.").
[15] *See id*. (*stating* "Experience has shown that physicians and nurses are usually viewed as the most credible messengers for communicating the plan's key messages.").

the determinants of health.[16] Through collaborative partnerships and multi-sector oversight, an Accountable Care Community can streamline efforts across the community and across numerous health issues for health promotion and disease prevention, access to quality services, and access to healthcare delivery. As public health experts have noted, Accountable Care Communities are well-positioned to comprehensively address a broad range of health issues while maximizing the community's assets.[17]

To that end, Ballad Health will take responsibility for establishing an Accountable Care Community model in the Geographic Service Area and will utilize resources to drive regional community health transformation. Members of the Accountable Care Community will be recruited based on their multi-sector leadership and their willingness to commit to be an accountable partner in the development of cohesive regional community health improvement efforts. A leadership council or board will govern the work of the Accountable Care Community and sub-committees may be developed based on sub-regional designations such as cities, counties, or other connected geographies. Members of the Ballad Health Population Health and Social Responsibility Committee and Department of Population Health Improvement will serve in standing leadership roles.



B. Ballad Health's Role in the Accountable Care Community

Ballad Health will work to align the components of the Accountable Care Community and target health improvement in our region in a way that creates clear advantage for payers (individuals, insurance companies, government payers, and employers), providers (physicians, hospitals, ancillary services), and

[16] *See* FAEGREBD CONSULTING, *Healthier By Design: Creating Accountable Care Communities* (February 2012), *available at* http://www.faegrebdc.com/webfiles/accwhitepaper12012v5final.pdf.
[17] *Id.*

the people and communities we serve—including underserved populations or those experiencing health disparities.

Within the Accountable Care Community framework, Ballad Health will be responsible for the roles outlined below to ensure that regional health transformation occurs. These defined roles will facilitate activities which shape policy and environment/infrastructure through local, state, and national level discourse and positively shape individual and group behavior through coaching, training, provider interaction, and community and personal education, engagement, and resource provision.

Ballad Health as Leader: Ballad Health will set the mission and the vision for regional health improvement through influential leadership and initiate corporate leadership within our communities and own organization through the development of community health policies and practices. In addition, we will create internal governance and compliance structures that are accountable to the Population Health and Social Responsibility Committee of the Ballad Health Board of Directors. This board committee will be responsible for oversight and compliance with all COPA commitments, including the Community Health Improvement Plan. Key members of this committee and Ballad staff leaders assigned to it will have dual roles associated with participation and leadership in the Accountable Care Community.

Ballad Health as Convener: Ballad Health will identify essential accountable partners across the region and recruit them to establish a regional Accountable Care Community model focused on the Community Health Improvement Plan. The Partners will adopt mutually accountable covenant commitments and focus comprehensive efforts around common objectives. The partners will include the breadth of organizations that are able to help the Accountable Care Community fulfill its charge of implementing comprehensive efforts to improve the health of the entire population in the Geographic Service Area.

Ballad Health as Facilitator: Ballad Health will be a catalytic force for change in our region, deploying human resources, educational resources, and advocacy resources to work hand in hand with accountable partners, providers of care, community members, and patients to accomplish regional goals.

Ballad Health as Grantor: Ballad Health will provide the basic funding to sustain the infrastructure for the Accountable Care Community. As required under the Community Health Improvement Plan we will provide financial investments to accountable partners to focus on priority efforts with clear, contractual expectations for how those funds will be used and a clear system for evaluating compliance, evaluation, and success.

Ballad Health as Implementer: Where gaps exist in community resources, Ballad Health will seek to fill those gaps by enhancing the capacity and capability of accountable partners or by creating Ballad Health departments, programs, or structures where needed.

Ballad Health as Evaluator: Ballad Health will ensure that effective evaluation mechanisms exist to drive ongoing accountability through a system of active supervision and evaluation for the Accountable Care Community initiatives. This may include working with outside evaluators from academic or other settings.

In order to connect and coordinate the clinical alignment efforts within Ballad Health and the community health improvement efforts being developed through the Accountable Care Community, Ballad Health will establish a new Department of Population Health. Oversight for this Department will

be vested with a senior executive, and staffed with leaders charged with financial compliance, physician relations, and community relations. The Department will be responsible for bridging the internal health system transformation with the external community health improvement efforts.

C. Challenges and Strategies

An Accountable Care Community is a locally-driven and locally-relevant organization. We recognize that challenges will exist in the development and implementation of the Accountable Care Community as we partner and collaborate with community organizations, but members of our executive teams have been instrumental in an extensive array of multi-stakeholder collaborative efforts as set forth in Exhibit A and have developed a host of significant regional relationships which will empower this work. We have also studied the experiences of accountable communities for health across the United States to identify the challenges each encountered and the lessons learned from their experiences. Among those Accountable Care Communities studied were the Live Healthy Summit County initiative in Akron, Ohio, the Pueblo Triple Aim Coalition in Pueblo County, Colorado, the Live Well San Diego initiative in San Diego County, California, the Trillium Community Health Plan in Lane County, Oregon, and the Pathways to a Healthy Bernalillo County initiative in Bernalillo County, New Mexico.[18] Research by the Institute of Medicine (now the National Academy of Medicine) illustrates that successful stakeholder and business engagement involves close alignment of providers, insurers, and businesses and community leaders with common data, common priorities, and focused investments in highest priority areas.[19] While successful engagement and action may face hurdles, local communities have overcome these hurdles where there is very strong common interest and high need for engagement given health status and other issues.

Based on the experience of these organizations that have implemented accountable communities for health, and our own executive team's experience in implementing multi-sector collaborative efforts, we have identified the following as the challenges we are most likely to encounter in the development of our Accountable Care Community and propose to address these challenges with the following strategies:

- Challenge: Building strong relationships to establish the Accountable Care Community partnerships.
    - Strategy: To effectively implement the Accountable Care Community, Ballad Health will build upon its existing relationships with community organizations and articulate clear responsibilities and expectations for each partner organization. The Work Groups

[18] The Prevention Institute was engaged by the Department of Vermont Health Access to identify national examples of innovative healthcare–community partnerships to improve population health. The Prevention Institute published their findings in a comprehensive report entitled "Accountable Communities for Health: Opportunities and Recommendations" which was published in July 2015. The report noted that "[r]elatively few communities in the country are implementing healthcare delivery and payment reforms that include environmental change strategies as a key pillar for improving population health" but identified these five initiatives as examples of national healthcare-community partnerships supporting community-wide environmental change efforts.

[19] *See, e.g.*, Lawrence Pyrbil et. al, *Improving Community Health through Hospital – Public Health Collaboration* (November 2014), *available at* http://www.aha.org/content/14/141204-hospubhealthpart-report.pdf; *and* Lawrence Prybil et. al, *A Perspective on Public–Private Collaboration in the Health Sector*, NAT. ACAD. OF MED. (November 2015), *available at* https://nam.edu/wp-content/uploads/2015/11/NAM-Public-Private-Collaboration-Perspective.pdf.

formed by the Applicants, which included many community organizations, will serve as an organizing base for this effort. Ballad Health has specifically addressed its strategy for recruiting and working with its accountable partners in Response #11: Plan for Community Partnership and Collaboration.

- Challenge: Aligning goals of partner organizations with the goals of the Accountable Care Community.
    - Strategy: To ensure that the goals and incentives are aligned within the Accountable Care Community membership, Ballad Health will recruit those partnership organizations that can effectively fill a need or serve a role within the Accountable Care Community structure. The development of the mutually accountable covenant commitments with each partner organization will allow the participating organizations to understand and accept shared responsibility for that organization's individual role within the Accountable Care Community. Details about Ballad Health's plans to align the goals of partner organizations may be found in Response #11: Plan for Community Partnership and Collaboration.

- Challenge: Coordinating Accountable Care Community partners and resources across multiple sectors operating with independent goals and under various constraints, including their knowledge base.
    - Strategy: It is necessary to have a leadership function whose responsibility includes ensuring communication pathways between activities and stakeholders. Ballad Health will establish the Ballad Health Department of Population Health to serve in this role and the Department will be responsible for coordination of the mission, vision, and implementation strategy with the Accountable Care Community to extend across all sectors and to all partners. In addition, Ballad Health will work through the Accountable Care Community to assess organizational capabilities and develop resources and training opportunities to help build the expertise and capacity of other organizations to contribute to overall success. Additional information about Ballad Health's strategy for coordinating partners and resources is included in Response #11: Plan for Community Partnership and Collaboration.

- Challenge: Utilizing data to effectively drive community health improvement.
    - Strategy: Large population wellness initiatives require changing the business culture to be more data-driven and evidence-based. Through its more robust analytic capability Ballad Health will have the capability needed to collect data from many sources, including from national and local sources and potentially from providers throughout the Geographic Service Area. The Accountable Care Community structure will allow Ballad Health to provide relevant and actionable data for use by the Accountable Care Community and to individual community organizations in support of prevention and care strategies. Ballad Health's plans to use data to effectively drive community health improvement are included in Response #9 The IT Strategy.

- Challenge: Setting the appropriate goals and measurements of success.
    - Strategy: In reaching across the multi-sector partnerships, it will be necessary to communicate the goals, proposed initiatives, measurements and engagement opportunities very clearly and simply. Ballad Health will use the work conducted by the State's Advisory Group and the Community Health Work Groups to develop a clear and straight-forward Community Health Improvement Plan. The overall measurements of

success will be developed with the Tennessee Department of Health and those measurements will be broken down into component measurements of success that can be addressed at the Accountable Care Community level and the individual partner level. Additional information about the appropriate goals and measurements of success are included in Ballad Health's Response #6: The Performance Measurement System. Ballad Health will be accountable for specific measures and metrics as agreed upon with the State.

V. Key Activities and Timing

Prior to Closing

Integrated Delivery System:

- Ballad Health will form the hospital operations and physicians group functional teams and initiate planning meetings.
- The Physician Clinical Council Charter will be finalized and Ballad Health will organize the initial meeting of the Physician Clinical Council.
- The IT Functional Team will continue meeting and develop a Request for Proposals for new IT system and a Request for Proposals for Population Health Analytics. The IT Functional Team will also be responsible for development of the IT Implementation Timeline and Plan.

Accountable Care Community:

- Establish Ballad Health governance, policy, and organization structures for oversight, management, implementation, and evaluation of the Community Health Improvement Plan and Population Health Medicine infrastructure, including development of the Population Health and Social Responsibility Committee of the Board.

First Three to Six Months After Closing

Integrated Delivery System:

- Ballad Health will establish the IT and Health Information Exchange ("HIE") leadership teams and governance structure to evaluate the IT and HIE options. These teams will begin the Intermediate work to derive IT functionality for shared information in two IT systems.
- The Physician Clinical Council will convene to identify the priority areas of focus and the foundational elements for the integrated delivery system, including mutually supportive covenants, with participation from all physician stakeholders.
- Determine structure for combination of the existing accountable care efforts.
- Determine feasibility for formation of a regional clinically integrated network
- Develop structure for integrated case management.

Accountable Care Community:

- Establish the Ballad Health Department of Population Health Improvement to include executive oversight, policy compliance, financial compliance, and staff roles that connect to each of the four component parts and their associated partners included in the Population Health Improvement Framework above.
- This Department will be led by a senior executive of Ballad Health whose primary responsibility will be achievement of the community health improvement aspects set forth in the COPA commitments. The senior executive will be the administrative liaison

to the Population Health and Social Responsibility Committee of the Ballad Health Board of Directors. The Committee will have governance oversight for compliance with the COPA commitments, providing strategic direction and reporting progress to the Ballad Health Board of Directors on a regular basis.

- Department personnel will have functional roles that include COPA policy and financial compliance and tracking, physician liaison roles to drive practice strategies, and community liaison roles to drive community based approaches and interface with collaborating organizations. In addition, the Department will partner with other areas of Ballad Health such as government relations and communications to drive policy decisions, and strategic planning to enact project management functions. Specific operational functions that need to be created to ensure that goals are achieved will either be housed directly in this Department or have dotted line reported relationships for accountability.

First Year After Closing

Integrated Delivery System:

- Ballad Health will select the new Common Clinical IT Platform vendor and systems and begin functional preparation for implementation with particular emphasis placed on organizational responsibility alignment, staffing needs assessment, and timeline development.
- Implementation planning for the new IT systems will be coordinated with the leadership of the Physician Clinical Council and the Ballad Board's Quality Committee.
- The Physician Clinical Council will identify initiatives focused on cross-facility collaboration to develop clinical protocols, reduce variation and waste, and increase quality based on identified best practices.
- Ballad Health's executive leadership will manage the intermediate work on systems integration or dual path functionality that will be required prior to full implementation of the integrated systems.
- The Physician Clinical Council will identify and coordinate medical staff leadership opportunities to encourage system-wide collaboration.

Accountable Care Community:

- Ballad Health will work with the ETSU College of Public Health, Community Health Work Groups, and the Tennessee Department of Health Officials to Finalize a Ten Year Community Health Improvement Plan, including gap analysis for needed regional services. Ballad Health will also develop annual tactical plans, target goals, and budgets to empower internal and external stakeholders to advance the long-term plan in an organized fashion.
- Ballad Health will identify the essential Accountable Care Community Partners, conduct readiness reviews of their staffing and organizational structures, and convene and charter the Accountable Care Community organization to support the activities outlined in the Community Health Improvement Plan, including measurement and evaluation systems developed with the State.

Twenty-Four Months After Closing

Integrated Delivery System:

- Ballad Health will utilize its operational expertise to facilitate the cultural evolution needed to become a model Community Health Improvement Organization that encompasses the best of traditional health care with innovation in population health management/medicine in order to enact community health transformation. This will include values development, brand implementation, as well as training and communication with internal staff and physician partners regarding the transformation strategy and implementation. In addition to high level focus on vision, specific training will occur with key areas such as case management, physician practices, urgent care centers, emergency departments, and behavioral health areas.
- Ballad Health will have established capabilities that may be needed with internal partners to support the Common Clinical IT Platform and Health Information Exchange functions to drive actions such as social need screenings, health risk identification, and immunization delivery and create effective tracking and evaluation systems.

Accountable Care Community:

- Ballad Health will identify needed alignment between the Common Clinical IT Platform, Health Information Exchange systems, and the tools of partners such as social agencies, state agencies, and community service boards in order to support health improvement goals through embedded protocols and analytic tools.

Annually

Ballad Health will conduct ongoing annual evaluations of activity effectiveness with its Accountable Care Community partners to ensure a strong system of process evaluation and continual improvement with plan adjustments made as needed. Success will be measured ultimately by our ability to achieve community health improvement related COPA measures, including long-term improvements in rates of disease. Incremental or process step measures will include successful implementation of the internal and external organizational structures needed to empower the plan including the Accountable Care Community model and the clinical alignment across the health system, the development of programs and their associated investments, and the achievement of incremental goals.

VI. Prioritization of Efforts and Associated Funding

The commitments outlined in the Application, such as the plan for community health improvement and its associated $75 million ten-year investment, were made based on conservative estimates of savings generated through merger-specific efficiencies. A nationally-recognized healthcare consulting firm was hired to verify these estimates. As such, we are highly confident in our ability to achieve and sustain the needed funding in the absence of any highly extraordinary or catastrophic event. If such an event were to occur, Ballad Health would work with the Department of Health to reprioritize efforts under the COPA.

VII. Sustainability of Efforts

While the timeframe for COPA investments set forth in the Application is for ten years, the ongoing annual investments, such as the investment in community health improvement, will continue as long as the COPA is in force. This ongoing investment will be essential to ensure continuing progress and that achievements are maintained. Ballad Health will work through the Accountable Care Community to build the organizational capacity of key partners and ensure

sustainability of efforts, rather than solely focusing on one-time funding mechanisms. In addition, we will require that sustainability mechanisms are in place for those organizations receiving grants. This will ensure that efforts can be scaled to more organizations, rather than creating a reliance on funding by a few.

VIII. Merger Specificity

Integrated Delivery System:

- The savings needed to fund the financial commitments, including the funding necessary to create an integrated delivery system, will only be generated by the merger. Investments and planning related to the consolidation of services and the standardization of practices and procedures, would raise significant antitrust concerns if undertaken together by two independent hospital systems in a joint venture arrangement.
- The creation of a fully integrated delivery system aligned around local community needs with financial support and effective resource use with the capabilities and benefits identified herein, in other filings, and in the Application is only achievable with the merger of the organizations, and would not be pursued under alternative arrangements if the parties remained competitors.
- As detailed in previous submissions, the Parties have pursued joint ventures for certain initiatives in the current competitive market.[20] However, none of those options would be substantial enough to drive the kind of fundamental system transformation noted here. Federal antitrust limitations make it impossible for the parties to achieve meaningful alignment of clinical resources substantial enough to derive the efficiencies needed to fund a plan of this magnitude. A merger is needed to achieve a meaningful reduction in the current clinical duplication and realign clinical resources.

Accountable Care Community:

- The ability to execute on, and move forward with, community health improvement and population health medicine strategies is dependent on the funding created by the merger efficiencies and the cohesiveness of efforts that will result from merger integration. Without the merger, any efforts will be significantly under-funded, disjointed, and insufficient in scale to achieve true progress. Without the COPA, there is no enforceable commitment to ensure this funding is made available or continues to be made available.
- While some activities, such as the formation of a regional Accountable Care Community could be accomplished without a merger, regional organizations do not have the financial capacity to drive the pace and scope of community health improvement set forth in the Application. The merger-specific savings will be critical to funding this plan. The Accountable Care Community and its partnerships provide a critical means of aligning all of the community into a collaborative effort and makes Ballad Health accountable for overall success.

[20] *See* Application, pages 12-14 for a description of the Parties' attempts to collaborate with respect to quality improvement methodologies and related projects but have been unsuccessful due to the competitive environment, the inability to share proprietary information, and the lack of a common clinical information system.

- The merger aligns the incentives of Wellmont and Mountain States with those of the community and insurers and provides the requisite infrastructure and financial support to address the critical goals of the Accountable Care Community. Through the Accountable Care Community, Ballad Health will provide for resources, funding of initiatives, and align incentives to target critical health needs in the community.
- Today, Wellmont and Mountain States only produce margins sufficient to fund their essential capital improvements and retain the cash flow needed to pay debt and sustain current bond ratings. Neither organization has the financial capacity to make the merger specific investments set forth in the Application without the elimination of duplication and increased operational efficiency. This efficiency cannot be derived while the two organizations remain separate.

Exhibit A
Experience with Multi-Stakeholder Collaborative Efforts

Members of the Wellmont and Mountain States' executive teams have extensive experience in developing, implementing, and managing multi-stakeholder collaborative efforts designed to coordinate action and resources to improve the health of a region. A representative sample of this experience includes:

Representative Experience in Development of Multi-Stakeholder Collaborative and Public Health Efforts

- Designed and later oversaw the implementation of the Primary Care Access and Stabilization Grant from the Federal Government after Hurricane Katrina, which rebuilt primary care for the uninsured in New Orleans under a capitated and NCQA certified PCMH model. This was later converted to a 1115 Medicaid waiver.
- Implemented a statewide effort to improve child immunizations. By applying financial incentives through Medicaid, and partnering with organizations throughout Louisiana (including companies like Walmart), Child Immunizations were improved in two years from ranking 48th in the nation to ranking 2nd in the nation - behind only Massachusetts.
- Negotiated and implemented the creation of a new teaching hospital in Baton Rouge, combining the use of Medicaid special funding with integration of the state's public research university (LSU).
- Sought and received approval by the Louisiana legislature to transform Medicaid and public funding to a new integrated care model. Called BayouHealth, this initiative began transitioning the state's payment systems from Fee for Service Medicaid to coordinated networks of care by region of the state.
- Negotiated the governance of the major teaching hospital in New Orleans, Charity Hospital (now University Medical Center) by developing an MOU between Tulane University, LSU, Xavier, Delgado and other stakeholders. This governance agreement was necessary in order to receive more than $400 million from FEMA. The deal was done, and the new hospital now stands in New Orleans as a private not-for-profit entity.
- Partnered with the Louisiana Healthcare Quality Forum on multiple initiatives to drive improvement of certain health care metrics.
- Passed the most sweeping reforms of the mental health system in Louisiana through the legislature, creating regional collaboratives in Mental and behavioral services through human service districts. By moving toward local collaboratives with authority and accountability for metrics, we saw improvement in the deployment of services, such as forensic assertive community teams, child and adolescent response teams, and community-based services.
- Negotiated the most sweeping federal 1115 waiver in the 45 year history of the federal Medicaid program, moving the entire state of Florida away from fee for service to coordinated networks of care (either risk-based managed care or what we called Provider Service Networks - which are now referred to as ACOs). Our reform in Florida actually predated the current ACO model. Received approval from the President of the United States and HHS Secretary, and Sought and received state legislative approval to implement this initiative. The initiative was later independently evaluated by the University of Florida Center for Medicaid and the Uninsured, and found to have reduced overall cost of care without sacrificing quality or patient satisfaction.

- Worked with drug companies and local collaboratives to improve utilization of medications. Florida led the nation by being the first to implement disease management initiatives in collaboration with providers and drug companies. This dramatically improved appropriate utilization of preventive medications for people with high utilization, and reduced overall costs for the Medicaid program.
- Collaborated with the University of South Florida to establish a mental health initiative to deploy appropriate mental health drug utilization for people with significant need.
- Implemented prepaid dental programs in Miami, where only a very small percentage of children were receiving dental care. Focus was to increase ability to measure who was responsible for the kids, and to infuse accountability for outcomes. Moved away from Fee for service altogether to the prepaid capitated model.
- Operated the state's largest provider based Provider Service Network in the Medicaid program. Integrated care with our own employed practices, and also collaborated with community based HIV/AIDS clinics, programs for children with serious health care needs, and community-based organizations.
- Developed the Louisiana Healthcare Quality Forum, a private, not-for-profit organization dedicated to reshaping health care. Led by a volunteer Board of Directors, the Quality Forum serves as a neutral convener, bringing providers, purchasers, payers and consumers together to drive improvements in health care quality, safety and value for Louisiana residents.
- Established the Alliance for a Healthier South Carolina, a coalition of more than 50 executive leaders from diverse organizations across the state working together to ensure that all people in South Carolina have the opportunity to have healthier bodies, minds, and communities while reducing the future cost of care.
- Developed the South Carolina Birth Outcomes Initiative, an effort by the South Carolina Department of Health and Human Services (SCDHHS) and its partners to improve the health of newborns throughout the state.
- Implemented the South Carolina Healthy Outcomes Program which now provides case management, primary care and behavioral health services to approximately 12,000 high-need, high-risk uninsured individuals through every hospital in the state.

<u>Representative Service in Multi-Stakeholder Collaborative Efforts</u>

- Participated in the Tennessee Institute of Public Health and ETSU Multi-sector Collaborative, a joint effort to strengthen community-based efforts to improve health, wellness and prevention in the identified distressed and at-risk Tennessee counties of Appalachian Tennessee by offering training, technical assistance, and mini-grants to enhance multi-sector collaboration.
- Board Member, Kingsport Chamber of Commerce
- Board Member, Virginia Center for Health Innovation.
- Board Member Virginia Hospital and Healthcare Association
- Founding Member of the Alliance for a Healthier South Carolina
- Founder of the South Carolina Medicaid Birth Outcomes Initiative
- IT and Communications Chair, Louisiana Health Care Quality Forum
- Board Chair, Greater New Orleans Fair Housing Action Council
- Health Committee Co-Chair, St Thomas Irish Channel Community Council
- Board member of managed care companies in Kansas and Kentucky
- Interim executive director of managed care company in Kansas

- Board member of community health clinics in Kansas and Kentucky (co-founder in Kentucky)
- Auditor of managed care companies in Florida
- Board of Directors, Kingsport United Way
- Fundraising Council, Bristol United
- Appalachian College Association
- Member, Northeast Tennessee Technology Council

Ballad Health
1. Strategy for Transitioning from Fee-For-Service to Value-Based and Risk-Based Models
2. Insurance and Value Payment Transition
3. The Structure for the Future
5. Plan for the New Infrastructure

Executive Summary: In this response, we discuss the experience Wellmont and Mountain States have with value-based and risk-based payment arrangements, their strategy to move from traditional fee-for-service to more value-based and risk-based models, and the timeline for their progression. We also address the structure and infrastructure needed to enact effective risk-based population health management.

As described in the Overview section, Ballad Health is committed to pursuing a transition to a value-based approach to health care delivery that includes enhanced pay-for-value and risk-based models of population health medicine. The essential pathways include greater alignment of both incentives and operations under a single physician-led council and overall leadership to use the resources available in the most effective way to address needs, improve outcomes, provide for greater financial stability and sustainability of care, and lead the way to greater ability for enhanced risk-based approaches. This may also include the development of a clinically integrated network in partnership with the independent physician community. Under these risk-based, value-based payment models and other initiatives, Ballad Health will be incentivized for achieving cost and outcomes of care, and have incentives to keep the population well.

I. Background

Successful navigation to risk-based models has proven challenging for many providers. Even though there is a vision for a new world order where providers take on more accountability and share more risk with payers, there is little consistency in the paths that either payers or providers are pursuing. As a result, experts have noted that there is a complex and narrow corridor to success.[1]

In Ballad Health's case, there are also unique challenges and barriers to success. The rural Appalachia region we serve is beset with poor health, low income levels, a declining and aging population, and the ongoing effects of economic decline.[2] Both Wellmont's and Mountain States' inpatient, emergency room, diagnostics, and pharmaceutical use rates are high by national standards and will be declining rapidly over the next ten years, creating a mandate for change in the traditional approach to health care delivery. The current infrastructure of Mountain States and Wellmont was built during a time of increasing utilization, much better economic conditions, and was designed for a fee-for-service model. Movement to a risk-based model requires significant investment in clinical and financial data systems, data analytics, care management processes and expertise, transparent close partnership relationships with the payers/employers, substantial capital resources, all connected by a well-developed vision and strategy. Health systems in regions of population growth are able to offset this decline in utilization and

[1] *Aim High*, J. HEALTHCARE CONTRACTING (June 2012) ("As an organization moves along the corridor, falling off either way can hurt the organization… Unfortunately, in a fee-for-service world, if you're effective at reducing utilization, you can hurt yourself. On the other hand, if you assume risk but you're unable to coordinate care, financially, you can find yourself in a very difficult position."), *available at* http://www.jhconline.com/aim-high.html.
[2] *See* Application for Certificate of Public Advantage, State of Tennessee, at 2.

maintain the necessary revenues to fund these investments. Because of the stagnant population growth in the applicants Geographic Service Area, this is not an option. Funding through synergies of the merger is required.

While both systems could continue to explore value-based models and assume more risk independently over time, neither system currently has the capital, resources, appropriate distribution of primary care practitioners and specialists, ambulatory network, or right infrastructure to successfully accomplish a comprehensive transition without a dramatic shift of emphasis and strategy. Since most risk-based models are structured around primary care practitioners (PCPs) neither system has a broad enough primary care network, geographically or numerically, to manage the critical mass of covered lives necessary to go "at risk" with our five largest payers. This critical mass of covered lives is required for spreading actuarial and utilization risk.[3] Therefore, a clinically aligned network must be developed which includes both employed and independent physicians who share financial and clinical incentives.

Wellmont and Mountain States have identified several keys to success with this transition which include:

- The financial flexibility to pursue risk on a large scale beyond the level of experimentation
- The financial ability to make up-front investments in needed infrastructure and personnel to manage health data and optimize electronic health records, to build analytic capabilities to stratify, prioritize, and track care management strategies, and to manage/coordinate the care of populations served
- Access to experience and expertise in development of risk-based models
- The existence of a cohesive clinically integrated network spanning the continuum of care, including a high-performing primary care network that encompasses a sufficient network of community physicians
- Community-level support for health improvement to complement clinical strategies for prevention and disease management (Accountable Care Community)
- Effective resources for development of strategy and evaluation of clinical processes for continual improvement
- A critical mass of patients large enough to cover the actuarial risks within a given population
- Transparent and closely aligned working relationships with payers to ensure reliability of data and strong engagement with members of the population served
- Achievement of shared risk-based goals across payer categories for application of broad population health management strategies
- Aligned incentives to drive collective strategy

Part of the rationale for the merger of Wellmont and Mountain States is that neither health system independently has the available resources to make these investments up front or access to a population large enough to merit the transition. The opportunity to make this transition with the resources and population needed for success is specific to the merger and is based on the clinical integration that can be achieved through Ballad Health. While an out-of-market merger would increase scale, it would not

[3] James Pizzo & Mark Grube, KAUFMAN HALL, *Getting to There from Here: Evolving to ACOs Through Clinical Integration Programs* (2011) ("To be fully successful in creating healthcare value, an organization needs to get to a point of having a 'critical mass' so that infrastructure and programs can be leveraged across a significant proportion of patients."), *available at* http://www.advocatehealth.com/documents/app/ci_to_aco.pdf.

result in clinical integration that inherently requires proximity of resources and shared patient experiences.

Further, the poor health status of our region creates a unique challenge for the transition to value-based care. Commitments to assume risk in an area of the country where health literacy is low and rates of disease and poor health behaviors are high requires an approach that focuses substantial resources on community health improvement. Without the savings generated from the merger, these investments would not be possible and the transition to risk-based models would be even slower or less likely in our region.

Our vision is to advance the process of value-based payment design with payers such that Ballad Health will be paid more for the value of the care it delivers than for the volume of that care. This will require Ballad Health to assume more risk for quality, cost, and outcomes while working with community partners to improve the overall health of the population.

II. Current Experience with Value-Based and Risk-Based Contracts

Wellmont and Mountain States each have experience with value-based models, including the formation of Accountable Care Organizations under the Medicare Shared Savings Program. In addition, both are participants in the current CMS Oncology Care Model, a highly competitive national model for care management of cancer patients. Mountain States participates in a shared savings arrangement for TennCare with AmeriGroup through its Integrated Solutions Health Network subsidiary. Both systems are fully participating in the "Episodes of Care" program that TennCare is rolling out over a five year period that started on January 1, 2015. Beyond this, the two health systems participate in scores of other value-based arrangements with various payers. The top five value-based programs for each system (ranked by population served) are summarized in Exhibit 1.1 (Mountain States) and Exhibit 1.2 (Wellmont) and submitted separately as confidential and proprietary information.

III. Strategy for Move to Risk-Based Models

During the first two years of the merger, Ballad Health will focus on the development of infrastructure and other key components of a successful transition roadmap:

Achieving financial flexibility and access to capital

Ballad Health will work to achieve the synergies and efficiencies outlined in the Application to generate the savings needed for capital investments. Ballad Health will also evaluate debt capabilities and cash flow options that would only be possible through the merger of the two systems.

Accessing expertise in development of risk-based models

Ballad Health will seek external resources to assist with the transition to risk-based models, such as third-party expertise related to best practices in risk-based strategy, and will identify partners through Requests for Proposals to achieve the IT and analytics capabilities needed to operationalize higher levels of population health strategy.

Making up-front investments in needed infrastructure and personnel

Ballad Health will develop the internal resources and acquire the infrastructure needed to manage health data and optimize electronic health records, build analytic capabilities to stratify, prioritize, and track care management strategies, and to manage/coordinate the care of populations served.

Developing a cohesive clinically integrated network spanning the continuum of care

Ballad Health will explore clinical integration opportunities including a high-performing primary care network that encompasses a sufficient network of community physicians, needed specialty physicians, ancillary services, home health, rehabilitation, pharmacy and other needed clinical resources to serve the needs of patients comprehensively and manage costs and outcomes across the continuum.

Building community-level support for health improvement to complement clinical strategies for prevention and disease management

Ballad Health will work with community partners to develop a robust Accountable Care Community, focused significantly on prevention and health education, and will resource its work to achieve long-term community health improvement goals in support of overall population health strategies.[4]

Solidification of systems for strategic planning and evaluation of clinical processes for continual improvement

Ballad Health will develop and/or re-align strategic planning systems and personnel to ensure continual process improvement efforts around clinical processes and to enhance efficiency of operations.

Achieving transparent and closely aligned working relationships with payers to ensure reliability of data and strong engagement with members of the population served

Ballad Health will work to reframe existing relationships with payers, including insurance companies and self-insured businesses, to move beyond the traditional contract relationship and connect strategic and operational components. These relationships will be structured around aligning goals for improved quality and lower cost in furtherance of shared business objectives.

Achieving shared risk-based goals across payer categories and within payer categories for application of broad population health management strategies

Ballad Health will position itself for sophisticated risk arrangements by working with payers to achieve shared goals across their populations. While some diversity in individual payer population goals is expected, too much variation will result in disparate or under-resourced efforts which are not conducive to the assumption of greater levels of population risk.

[4] *See* Responses to Questions Submitted November 22, 2016, Overview & Response 11 (Plan for Partnership and Collaboration with Community Organizations) for a more detailed discussion.

Alignment of goals and objectives across the regional population will allow Ballad Health to make greater investments and assume higher levels of risk. This focus will include alignment of goals within similar commercial populations, similar Medicaid populations, and similar Medicare populations as these categories of patients have distinct health characteristics.[5]

Aligning incentives for performance and outcomes under risk-based models

Ballad Health will work to facilitate aligned incentives between providers and payers to achieve a shared approach to quality metrics, service metrics, cost metrics, and access metrics. This alignment will ensure a collective focus on progress and the ability to succeed in increasingly sophisticated risk-based arrangements. Better alignment and focus on the current array of measures will be essential to the transition to risk-based models.

IV. Addressing Variation Between Payer Populations

Variation exists between major payer categories due to the different populations served. The Parties have addressed the variations between public sector and private sector payers and their strategies for managing these variations below:

A. Public Sector (Medicare/Medicaid) Strategy

High-need, high-cost patients are concentrated principally in the Medicare and Medicaid populations.[6] In the elderly Medicare population, the high-need, high-cost patient profile often includes those beneficiaries with multiple chronic conditions, or those who are nearing the end of life.[7] Among Medicaid populations, mental illness or social determinants, such as homelessness, are drivers of persistently high spending patterns. While programs like the Medicare Shared Savings Program offer promising approaches and resources for Medicare Fee-for-Service populations, it is often challenging to extend these expanded services to Fee-For-Service patients. Similar dynamics exist on the Medicaid side. As a result, patients with similar clinical profiles in the very same practice may not be able to access the same level of care management services.

One strategy for dealing with this is to align goals within certain patient categories. Research has shown that aligned patient intervention programs operate most efficiently when all the patients with complex conditions are eligible to participate in the program, regardless of payer.[8] This leads not only to better population health outcomes, but ultimately drives down the cost of care. By aligning multiple payers, Ballad Health can coordinate quality measurement and reporting requirements in a way that amplifies incentives to undertake certain performance improvement activities. These incentives can then be used to invest in the infrastructure needed for complex care management.

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[5] *See* Section IV, *infra*.
[6] *Payment to Promote Sustainability of Care Management Models for High-Need, High-Cost Patients: Insights from the Healthcare Transformation Task Force*, HEALTH CARE TRANSFORMATION TASK FORCE; *available at*: http://www.pbgh.org/storage/documents/publications/HCTTF_Payment_to_Promote_Sustainability_of_Care_Management_Models.pdf.
[7] *Id.*
[8] *Id.*

As value-based payment programs are evaluated for public sector patients, it will be critical for Ballad Health to develop care management and coordination processes that improve quality and patient experience, but avoid unnecessary health care costs. Elements that may be considered as part of the care management processes include:

- Rapid identification of high-need, high-cost, and rising-risk patients
- Engagement of patients and family caregivers
- Utilization of health assessments and social/behavioral screening tools
- Scalable care teams
- Coordination of care across patients, caregivers, and providers
- Targeted disease management programs
- Cost-effective treatment
- Timely transition of care to the most appropriate service level and
- Rigorous measurement and evaluation

Ballad Health will look for ways to align care management programs across the system so that all patients may access the same level of care management services regardless of payer. This will be particularly important for those high-need, high-cost patients typically covered by public programs. By aligning care management processes throughout the whole organization, Ballad Health will be able to test, implement, and expand care management processes to patients with similar clinical profiles regardless of payer source.

B. Private Sector (Insurers, employers, and individual consumers)

Private sector patients are generally younger and healthier than public sector patients and demonstrate more episodic care needs. Patients covered by private sector payers usually place more emphasis on access to care, patient experience and convenience because of the episodic nature of their health care needs. In addition, since almost all private sector payers require some level of cost-sharing, out-of-pocket costs are crucial to provider choice.

Leveraging healthcare data analytics, innovative reimbursement structures, and patient-centric outreach will be important elements of Ballad Health's strategy to successfully move private sector patients to value-based care. The implementation of the Common Clinical IT Platform will allow providers across the region to access patient records in an efficient manner. Aggregation of patient data at the system level will allow Ballad Health to pursue sophisticated data analytics programs that can drive quality initiatives and improved outcomes.

On the cost side, Ballad Health will explore bundled payments and reimbursement for episodes of care that include financial incentives for providers. These initiatives will be especially important in areas like orthopedics and oncology where significant savings can be achieved through coordination of care and reduction of variation. The Physician Clinical Council will play an important role in implementing best practices across the system to achieve higher quality outcomes and reducing clinical variations which should yield significant savings.[9] Ballad Health

[9] See Responses to Questions Submitted November 22, 2016, Overview at 5 and 13-14 for a more detailed discussion of the Physician Clinical Council.

will also invest in cost-effective and accessible care options, like urgent care centers and telehealth, that allow patients to access care in a timely and affordable manner.

Coordination of patient engagement and population health management programs may help reduce the administrative and financial burden on providers who wish to deliver these services to their patients, but lack the time, manpower, or budget to do so. Working together with employers, community partners, payers, and providers through the Accountable Care Community, Ballad Health can help coordinate prevention and diagnostic care services and improve chronic disease management. These early intervention efforts have the potential to drive down long-term health care spending on some of the most costly conditions patients may face over their lifetimes.

V. Timeline for Movement to Risk-Based Models with Payers

The merger will allow Ballad Health to pursue risk-based models on a significantly larger scale, with a more integrated structure, and at a much faster pace than if either Wellmont or Mountain States were pursuing these models separately. The primary details and the proposed timing for this transition are listed below:

- Spring 2017
    - Merger closes.
    - Rate cap and rate reduction commitments go into effect for all Principal Payers.

- 2017- 2018
    - Separate Mountain States and Wellmont charge masters are replaced by a Ballad Health charge master that includes all inpatient and outpatient services.
    - Separate Mountain States and Wellmont managed care contracts are replaced by Ballad Health managed care contracts with all Principal Payers. The Ballad Health managed care contracts with the Principal Payers are expected to include value-based and risk-based model components. For the risk-based model components, Ballad Health plans to establish go-live dates as follows:
        - All risk-based model components of existing Mountain States and Wellmont contracts would continue from the date of closing into the future.
        - One new risk-based model contract would commence on January 1, 2019.
        - One new risk-based model contract would commence on January 1, 2021.
        - Ballad Health would initiate risk-based model contracts for any remaining Principal Payers that do not already have at least one risk-based model component in their contracts no later than January 1, 2022.

      By January of 2022, all of the Principal Payers are expected to have a risk-based model/population health/partnership relationship with Ballad Health that includes aligned incentives.

- 2017-2019
    - Separate Mountain States and Wellmont contracts are replaced by Ballad Health managed care contracts for all non-Principal Payers. The Ballad Health managed care contracts with non-Principal Payers may include value-based components and

may include elements of risk if connected to the broader shared goals of the Principal Payers.
    - No later than October 1, 2019, all of Ballad Health's managed care contracts have been completed with all payers.

- 2019 and Beyond
    - Following the development of the needed infrastructure within the first two years following the merger, Ballad Health will pursue progressively higher levels of risk-based contracting with payers. This may include the potential for some full-risk arrangements depending on payer interest.

VI. The Structure and Infrastructure Needed for the Future

The transition to more risk-based contracts requires a focus on population health management. The following are the component systems needed to enact effective risk-based population health management. Not only are these elements required, but they must function together cohesively and strategically to drive successful outcomes. Each area inherently includes leadership resources, personnel resources, information management resources, and technological resources.

A. Health Information Systems

A robust, health information system is necessary to build a scalable platform for population health management. The Common Clinical IT Platform will serve as the backbone of Ballad Health's population health strategy, but it is the effective use of multiple, connected health information systems that will facilitate the population health management mission.

The parties have committed to the adoption of a Common Clinical IT Platform to ensure that information needed to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. Specifically, the Common Clinical IT Platform will assist with the new structure in the following ways:

- It will allow providers in Ballad Health the ability to quickly obtain full access to patient records at the point of care.
- It will facilitate the increased adoption of best practices and evidence based medicine implemented by Ballad Health's Clinical Council.
- It will be used to implement immediate system-wide alerts and new protocols to improve quality of care.
- It will help reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

In addition, to the adoption of the Common Clinical IT Platform, the parties have committed to meaningful participation in a region-wide health information exchange to promote coordination among community providers. Participation in the health information exchange will facilitate the population health management efforts in the following ways.

- It will support access to health information across the community for Ballad Health providers as well as independent providers, medical groups and facilities.
- It will encourage and support patient and provider connectivity to Ballad Health's integrated information system.
- It will provide key data security and relevant protocols to all users.

- It will further facilitate better patient care, coordination of care, and decrease the unnecessary duplication of health care services.

These health information systems will support improved clinical-decision making for all providers and leverage real-time data in support of more sophisticated population health management strategies. Together these systems will position Ballad Health to pursue more risk-based contracts.

B. Financial and Clinical Analytic Systems

Risk-based contract models require a new type of financial skill set. If the organization is inaccurate when modeling medical expenses, significant losses can be experienced. On the other hand, with accurate modeling, the ability to manage care, and no unexpected occurrences, there can be significant returns. While both Wellmont and Mountain States have experience with risk-based and value-based contracting, the shift towards population health management will require new and refined financial information systems. Specifically, Ballad Health will need to cultivate or acquire the following competencies:

- Actuarial expertise to model medical expenses;
- Insurance risk management to identify appropriate stop-loss and reinsurance needs;
- Networking and contracting strategies;
- Predictive modeling to identify rising risk patients and; and
- Physician-level reward systems.

Ballad Health will need to track the unit and case cost for all services for which it will be at risk under a value-based contract to ensure that costs are managed while quality and outcome targets are pursued. As a result, the availability and accuracy of this financial information will be critical to Ballad Health's transformation. Not only will Ballad Health need to track its own cost of care, but it will also need to determine the care costs of partners that will be sharing risk. Strong relationships with outpatient providers will be particularly important to for capturing and accessing data on outpatient costs.

C. Quality Information Systems

As a first step in the transition toward population health management, Ballad Health will seek to expand contracts that offer patient satisfaction and care quality bonuses. Incentivizing patient satisfaction will encourage providers to engage patients in their care, and engaged patients tend to be healthier and less costly at the population level.[10] Incentivizing quality may reduce costs by increasing adherence to evidence-based care protocols that lead to improved outcomes.[11]

As Ballad Health moves towards more risk-based contracting, more emphasis naturally will be placed on reducing costs. It will be critical for Ballad Health to maintain a dual focus on quality while it pursues these types of contracts. A strong data infrastructure and expertise also will be required in order for providers to meet quality targets and proactively, effectively, and efficiently manage the care of a specific patient population under a value-based contract. For contracting purposes and

[10] Terri Welter, et. al, ECG MGMT. CONSULTANTS, *Steps for Transitioning to Population Health Management* (Winter 2015), *available at* http://www.ecgmc.com/thought-leadership/articles/steps-for-transitioning-to-population-health-management-1.
[11] *Id*.

population health purposes, Ballad Health will invest in development of quality information systems to track quality of care across the continuum.

Many of the initiatives to reduce variation and improve quality across the system will be tied to new contracting practices designed to ensure collaboration between Ballad Health and the payers. These practices will be designed to use the analytic strength of the payers to identify high cost services and processes, and then align the interest of the payer and Ballad Health to reduce cost and improve the overall patient outcome. From contracting to implementation, the objective is to identify where the opportunities for patient outcome improvement and cost reduction exist, and to then collaborate with physician leadership to execute legitimate and scalable strategies throughout the region to achieve the mutual objectives of the payer and the health delivery system.

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

D. Care Management and Coordination Functions

Care coordination systems will be critical to the efficiencies needed for successful risk-based contracting. Case management software is important to support the workflow of case managers, provide actionable care management plans at the point of service, and to provide the data for analysis of risk and care plan adherence and efficacy. Ballad Health's Clinical Council has been charged with developing the uniform guidelines, protocols, and outcome measures that will be implemented across the system. Data from multiple locations and providers, both employed and independent, will be collected and synthesized into comprehensive care plans, allowing providers to understand an individual patient's goals. At the same time, personnel in the Ballad Health Department of Population Health will be measuring population-level goals that affect all patients.

Primary-care led strategies, like patient-centered medical homes ("PCMHs"), will be an important component of the system's population health management efforts. PCMHs include a multi-disciplinary care team, led by a primary care provider, that provide coordinated, continuous care. While a few PCMHs already exist in the area, Ballad Health will need to expand the support structure for these organizations and resources available as the number of managed lives grows.

E. Clinically Integrated Provider Network

Effective population health management requires continuous integration of clinical services across providers, care settings, and medical conditions—but not necessarily under single ownership.[12] Roughly 70% of the physicians in the Geographic Service Area are independent, and Ballad Health is

[12] Lola Butcher, *Clinical Integration Supports Population Health Management*, LEADERSHIP+ (Nov. 17, 2016), *available at* http://www.hfma.org/Leadership/Archives/2016/Fall/Sidebar_Clinical_Integration_Supports_Population_Health_Management/.

committed to developing structures that align clinical services with these groups as the population health and risk-based contracting efforts grow.

While organizations that share significant financial risk can technically perform joint contracting without being clinically integrated, they often struggle to manage risk. Ballad Health will need to invest in clinical integration core competencies and build structures to share risk and rewards with independent providers. These include selection of high quality providers committed to cooperating to achieve common goals, mechanisms to monitor and control utilization of health care services and resources, initiatives to support care coordination, quality improvement and cost management, and data collection and dissemination

F. Accountable Care Community Support Systems

Finally, in furtherance of its population health management and risk-based contracting goals, Ballad Health will need to invest significant resources in the systems needed to support the Accountable Care Community. These systems and resources are more fully described in the Overview Section and Response #11 - Plan to Partner and Collaborate with Community Organizations.

Exhibit 1.1

Top Five Value-Based Programs Currently in Place at Mountain States

To be submitted pursuant to CID.

Exhibit 1.2

Top Five Value-Based Programs Currently in Place at Wellmont

To be submitted pursuant to CID.

Ballad Health
4. Comprehensive Regional Strategy to Deliver Equitable and Efficient Care

Executive Summary: In this response, we outline the strategy for Ballad Health to deliver equitable and efficient care across the entire service area. Ballad Health will accomplish these objectives through (i) the establishment of an integrated health delivery system with a focus on population health that includes strategies for equitable access and care coordination to reduce disparity; (ii) a liberal charity care and self-pay policy that is consistent with the IRS 501(r) regulations; and (iii) a cultural and linguistically appropriate approach to services that formalizes Ballad Health's expectations for all employees who interact with disadvantaged individuals and people living with disabilities.

According to the Centers for Disease Control and Prevention, health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[1] The types of health care inequity that exist in the Geographic Service Area include similar factors to those that exist nationally including inequities resulting from race, disability, educational attainment, and economic status.[2] In addition, there are distinct characteristics of the Geographic Service Area that contribute to disparity, especially characteristics that affect rural populations and their ability to access services.[3] The region is also disproportionately impacted by low educational attainment levels and poverty in relation to other factors such as race or ethnicity.[4] A locally based health system, governed by people who live, work, play, and pray in the community, has the best opportunity to address the unique needs of the region. By adapting national best practice interventions to the specific aspects of this area and its Southern Appalachian culture, Ballad Health has the opportunity to make meaningful improvement in an area plagued with health inequities.[5]

Ballad Health strives to be a health care system that (i) operates effectively and efficiently to ensure all people get the care they need and (ii) invests in keeping them healthy. To do this, Ballad Health must specifically address the health inequities and inefficiencies in the region. Community Catalyst, a national non-profit organization, has done extensive work on health inequities and recommends the following six reforms to reduce disparities in healthcare:

1) Expand coverage and access to care;
2) Improve data collection and metrics on disparities;
3) Implement socioeconomic risk adjustments in payment reform;
4) Ensure providers are culturally competent;
5) Reallocate resources to address social determinants of health; and

[1] *See* CENTERS FOR DISEASE CONTROL AND PREVENTION, HEALTH EQUITY, *available at* https://www.cdc.gov/chronicdisease/healthequity/.
[2] *See, e.g.*, DIV. OF HEALTH PLANNING, TENN. DEP'T OF HEALTH, 2014 STATE HEALTH PLAN, *available at https://www.tn.gov/assets/entities/hsda/attachments/2014_Update_to_the_Tennessee_State_Health_Plan.pdf.*
[3] *Id.*
[4] Application of Certificate of Public Advantage, State of Tennessee, Exhibit 8.1 (Tennessee counties comparison in poverty and education as compared to Tennessee averages).
[5] Although producing a small overall negative impact on total population health given the relative size of their population, a small non-white population could experience even greater disparities given their underrepresentation.

6) Promote a more diverse workforce and use of community-based providers such as Community Health Workers.[6]

These policy recommendations provide guidance to the disparities strategy proposed for Ballad Health. Ultimately, a health system governed by people who live, work, play, and pray together has the best opportunity to address the unique needs of the region. Ballad Health will do this by adapting national best practice interventions to the specific aspects of our area and its Southern Appalachian culture.

I. Strategies for Equitable Access and Care

Ballad Health's approach to addressing disparities is shaped by the not-for-profit orientation of Wellmont and Mountain States—to meet the health care needs of patients regardless of their ability to pay, and provide outreach services to those who are geographically limited in their access. These efforts have been supported by a variety of efforts, including direct contributions of care by the systems, contributions of dollars by the systems to community-based organizations which organize access to care, and through our foundations, raising funds to meet non-medical patient needs which are often not met elsewhere through insurance coverage or government assistance programs. Both systems have also availed themselves of grant funding to provide assistance for vulnerable individuals. But these sources of funding are often inconsistent, often restricted to specific populations or problems, and are almost always too little regardless of the best intentions. The merger has the opportunity to create greater discretionary financial resources within Ballad Health as a result of the synergies generated. The Parties believe the new health system will be better positioned to proactively address health disparities experienced by patients and the broader population.

Though Wellmont and Mountain States collectively provide $164 million[7] in charity care and support for self-pay patients, those resources primarily cover clinical care in our hospitals and clinics. To better address health disparities and increase the provision of equitable care, Ballad Health will use merger efficiencies to invest in systems of care coordination, including social screening, navigational, and case management resources that do not currently exist or cannot be appropriately scaled in the current resource constrained environment. These plans will be fulfilled through the $140 million of expanded services committed through the merger.

According to Kevin Fiscella in the *Annals of Family Medicine*, "Equitable health care means more than elimination of bias, it also means creation of patient-centered systems of care that support healing and caring relationships that are responsive to patients' needs, wishes, and context. Improving equity requires aligning health care resources and capability with patient needs, particularly patients who have been historically underserved."[8]

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[6] Marcia Hams & Josh Sager, COMMUNITY CATALYST, *Demographic Health Disparities and Health System Transformation: Drivers and Solutions* (Nov. 2015), *available at* http://www.communitycatalyst.org/resources/publications/document/Policy-Brief-Demographic-Health-Disparities-Final.pdf.

[7] 2013 Figures. *See* Application for Certificate of Public Advantage, State of Tennessee, at Exhibit 8.4 (Consolidated Financial Statements).

[8] Kevin Fiscella, *Health Care Reform and Equity: Promise, Pitfalls, and Prescriptions*, 9:1 ANN. FAMILY MED. 78-84 (Jan. 2011), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3022050/.

Like efforts nationally to build Health in All Policies,[9] it is our intent to build disparities strategies into all clinical and business policies and processes throughout Ballad Health. To achieve this, Ballad Health plans to take the following steps:

- Use data and analytics to (i) not only identify vulnerable individuals in our patient population, but importantly to identify vulnerable individuals in the community who are not connected with a regular source of care and (ii) design strategies and services to reach individuals and motivate them to action and remove barriers in their way.
- Embed systems for equitable care within all administrative and clinical processes rather than considering health equity as the problem of the population health department. This includes creating work flows at hospital, clinic and urgent care registration as well as at the bedside to identify individual needs and translate them into navigation and case management action plans that connect people to community-based resources to help meet transportation, food, housing, behavioral health, and substance abuse needs.
- Develop and deliver education and prevention resources connected to the Community Health Improvement Plan including screenings and immunizations.
- Develop, deliver, or connect people to family support services for early childhood development, perinatal resources, effective parenting, and Neonatal Abstinence Syndrome avoidance and treatment.
- Connect people to primary care and medical home programs either within Ballad Health, the network of community physicians, Federally Qualified Health Centers or Rural Health Centers and incentivize providers to invest time in patient engagement around social needs.
- Work with payers, especially Medicare and Medicaid managed care plans, to develop more cohesive systems of care coordination and to incentivize accessible, high-quality, and efficient care for these populations and reward effective management of social needs and determinants of health in addition to traditional payment for service.
- Work specifically with vulnerable populations, such as the high-need, high-utilizing uninsured individuals suffering from mental health and addictions, including pregnant women, as noted in the Application.[10]

II. Charity Care and Self-Pay Policies

In order to ensure low income patients who are uninsured or under-insured are not adversely impacted due to pricing, Ballad Health has committed to adopt a charity care policy that is substantially similar to the existing policies of both Parties and consistent with the Internal Revenue Service's final 501(r) rule. For patients who qualify, Ballad Health will provide for the full write-off of amounts owed for services by patients with incomes at or below two hundred percent (200%) of the federal poverty level. For patients who do not qualify for full write offs, Ballad Health will discount services in compliance with rule 501(r) according to the ability of individuals and families to pay and will communicate discounts according to policy prior to service delivery or at the point of service to avoid creating any barrier to essential care.[11] Practices will include payment plans that are manageable for patients and their families

[9] LINDA RUDOLPH ET. AL, HEALTH IN ALL POLICIES: A GUIDE FOR STATE AND LOCAL GOVERNMENTS (2011), *available at* http://www.phi.org/resources/?resource=hiapguide.

[10] *See* Application at page 99.

[11] This is a new commitment that the Parties have agreed to adopt as a result of discussions with the Southwest Virginia Health Authority. This commitment represents a higher level of charity care than Wellmont and Mountain States collectively offer now.

according to their individual circumstances. Ballad Health will work to connect people to insurance coverage and state and federal programs for which they qualify.

Ballad Health will inform the public of its charity care and discounting policies in accordance with all applicable laws and shall post such policies on its publicly accessible web site. The activities related to charity care will occur immediately upon closing of the merger and will remain in place as long as the Certificate of Public Advantage remains in effect.

Ballad Health will also commit that neither Uninsured Patients nor Underinsured Patients will be charged more than amounts generally billed ("AGB") to individuals who have insurance covering such care in case of Emergency Services or other Medically Necessary Services.[12]
Financial assistance eligibility for patients of Ballad Health will be determined by a review of the Application for Financial Assistance, documents to support the Application for Financial Assistance (i.e. income verification documentation), and verification of assets. Ballad Health's financial assistance determinations will be based on National Poverty Guidelines for the applicable year. Ballad Health will adhere to the IRS regulatory guidelines set forth in Section 501(r) of the Internal Revenue Code.

The commitments to patients who qualify for charity and the uninsured or underinsured will be implemented on a consistent basis across the Geographic Service Area and will apply to all Ballad Health facilities, thus ensuring equitable treatment for all.

III. Cultural and Linguistically Appropriate Approach to Services

Ballad Health is committed to building a culture of responsiveness and proactive engagement with underserved populations across the organization. This will require continuing education related to equitable care and redesign of associated processes as well as a deeper, more comprehensive understanding of the distinct characteristics of different populations in different geographic regions.

Ballad Health will use the National Standards for Culturally and Linguistically Appropriate Services in Health Care (the "National CLAS Standards") as a guide for this effort.[13] According to the HHS Office of Minority Health, “The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.”[14]

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[12] “Uninsured Patients" are those with no level of insurance or third-party assistance to assist with meeting payment obligations. “Underinsured Patients" are those with some level of insurance or third-party assistance but with out-of-pocket expenses that exceed financial abilities. The AGB percentage will be determined using the look-back method utilizing the lowest percentage for all facilities per the IRS regulatory guidelines set forth in 501(r). "Emergency Services" are defined in accordance with the definition of “Emergency Medical Conditions” in Section 1867 of the Social Security Act, 42 U.S.C. § 1395dd. "Medically Necessary Services" are defined by Medicare as services of items reasonable and necessary for the diagnosis or treatment of illness or injury and are Services not included in the list of “particular services excluded from coverage” in 42 CFR § 411.15.

[13] DEPT. HEALTH & HUMAN SERVS., NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH CARE, *available at* https://www.thinkculturalhealth.hhs.gov/clas/standards.

[14] OFFICE OF MINORITY HEALTH, DEP’T HEALTH & HUMAN SERVS., A BLUEPRINT FOR ADVANCING AND SUSTAINING CLAS POLICY AND PRACTICE (Apr. 2013), *available at* https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf.

These fifteen standards are grouped according to one principal standard and three themes. The principal standard states the organization will strive to:

> *"Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs."*

The three themes of the remaining standards are (1) Governance, Leadership and Workforce, (2) Communication and Language Assistance and (3) Engagement, Continuous Improvement and Accountability.[15]

Within 12 months of closing, Ballad Health will complete an assessment of the organization's capability to meet these voluntary standards and assemble a work plan designed to advance the goal of the principal standard. The health system will work with the Offices of Minority Health and Health Equity in Virginia and the Office of Minority Health and Health Disparities Elimination in Tennessee to develop this work plan.

IV. Why The Promotion of Health Equity and Reduction of Disparities is Merger Specific

Promotion of health equity and reduction of disparities has gained increasing attention in health services and public health circles, yet progress has been slow.[16] One reason is because health systems tend to set their strategies at the least common denominator – typically federal or state law. For example, where the ADA provides guidance and standards related to treatment afforded to individuals living with disabilities, systems find they may reduce or eliminate their business risk by simply meeting the minimum standards and going no further. The National CLAS Standards outlined above are voluntary, not mandatory, and charity care requirements are spelled out in detail by federal regulation.[17] Another reason health systems haven't pursued more aggressive health equity policies is because they have little financial incentive to do so. While incentives for quality and patient safety improvements are common, few payers or industry organizations have adopted health equity requirements or incentives to address these disparities.

The Applicants have proposed to voluntarily exceed the minimum requirements of the law because (i) the merger frees up resources to be devoted towards vulnerable populations and (ii) because the reduction in disparities is important to state goals. The COPA provides a mechanism to ensure these goals are pursued faithfully by the new health system. Without the financial synergies of the merger, both health systems would lack the financial resources to pursue these strategies in the absence of payer incentives. Without the enforceable commitments made under the COPA, neither health system would be compelled to offer more generous commitments to disadvantaged and disabled individuals than required by state and federal law.

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[15] *See* DEPT. HEALTH & HUMAN SERVS., NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH CARE, *available at* https://www.thinkculturalhealth.hhs.gov/clas/standards.

[16] Joseph R. Betancourt, *Ushering In The New Era Of Health Equity,* HEALTH AFF. (October 31, 2016) ("Aside from progressive leaders and early adopters who began to place equity on the same footing as the other pillars of quality, the overwhelming majority either remained reluctant to admit that disparities existed in the health care settings they oversaw, or went on the slow burn, multiyear path of 'studying the issue and what could be done.'"), *available at* http://healthaffairs.org/blog/2016/10/31/ushering-in-the-new-era-of-health-equity/.

[17] *See* IRS 501(r) Regs. (26 C.F.R. Parts 1, 53 & 602).

Ballad Health
6. Performance Measurement and Management

Executive Summary: In this response, we describe the current state of performance measurement systems within Wellmont and Mountain States and outline the performance measurement approach that is needed to transition to, and thrive under, a value-based population health model. This performance measurement system will evaluate both internal strategies for population medicine and external strategies for community health improvement.

I. Current State of Performance Measurement Systems

Mountain States and Wellmont both utilize performance management and measurement systems designed to link the mission, vision and values of each organization to the work performed at the point of care and produce the desired outcomes. While each organization currently organizes and operates these systems differently, they have several components in common:

- **Governing Structures**: Board Quality Committees, Board Finance Committees, Facility Medical Staff Committees, and Executive Leadership Teams are all involved in distinct ways in setting organizational performance goals for financial, service, and quality performance.
- **Management Support Departments and Functions**: Quality, Strategy, Performance Improvement, Organizational Development and Training, Human Resources, Finance, Managed Care Contracting, and Analytics departments are all involved in the development of strategic and tactical plans and budgets and in the oversight of implementation and evaluation efforts.
- **Processes**: Strategic Planning, Budgeting, Incentive Pay, Team Member Evaluation & Development, Performance Reporting, Lean/Value Optimization, and Project Management processes all support a system of continual improvement, evaluation, and feedback.
- **Tools**: A variety of Performance Dashboards, Project & Performance Management Tools and Learning Platforms support the work of data collection, management, and evaluation within both organizations. Both organizations use a variety of outsourced tools to complement internal capabilities for measurement and analysis. One such set of resources is provided by MedeAnalytics—a company which provides tools to manage cost, quality, revenue, and risk.
- **Standards**: Both external and internal standards drive performance including Accrediting & Certifications (e.g. Joint Commission, State Trauma), Value Based Contracting (e.g. HEDIS, HCAPS, QHIPS), Public Reporting (e.g. Leapfrog, Healthgrades, Carechex), Bond Rating Agencies (e.g. Moody's, S&P), Evidence Based Care (e.g. Choosing Wisely, ACO, bundles) and organizational balanced scorecards.[1]

These components support a continuous improvement feedback loop for each organization's governing board, management, and team members that is used to set goals and objectives, deploy resources, and measure, report, modify and reward performance.

[1] *See* Response #1 Exhibit 1.1 (Mountain States) & Exhibit 1.2 (Wellmont) (both submitted under CID).

II. Process for Establishing Ballad Health Performance Measures

Pending approval by both Tennessee and Virginia, it is anticipated that the merger will close in the first quarter of calendar year 2017. The FY18 strategic planning, budgeting and performance management process for each separate organization will be well underway in preparation for a July 1 fiscal year start.[2] Given this anticipated timing, the leadership of both organizations has determined that the FY18 strategic planning, budgeting and performance management process will progress for each Ballad facility and business unit under their respective organization's current model (i.e. Mountain States facilities will proceed with Mountain State's performance management process for FY18). The performance management processes will be unified for FY19.

The parallel performance management processes for FY18 will be "seeded" by executive management with high-level unified goals for Ballad Health's productivity and financial performance, quality and service, and major initiatives (including any COPA initiatives required during the time period). Both organizations will proceed in parallel to develop strategies and metrics at the facility/business unit/corporate support level. The results of this effort will be reconciled on the back-end to eliminate duplicative efforts and expenditures or competing strategies.

After an iterative process to refine goals, strategies and metrics, unified system-level balanced scorecards/dashboards will be constructed for quality and service, financial performance, value-based purchasing, and incentive pay. An additional Dashboard will be created based on the COPA Index in Tennessee and the Quantitative Measures in Virginia. These dashboards will serve as performance review mechanisms for the Ballad Board's Finance, Quality and newly created Social Responsibility and Population Health Committees, as well at the newly formed Clinical Council.

Each dashboard will cascade down to the facility and business unit level. The strategic initiatives in place to pursue these goals will be entered into a corporate-wide performance management system which combines analytics with action planning, resource assignment, progress tracking and performance monitoring to ensure that everyone in the organization is on the same page at the same time, working toward the right goals and achieving the best possible results. Corporate management review of these dashboards and timelines will take place at regularly scheduled Senior Executive Operations Meetings (weekly), Market Operations Reviews (monthly), Market/Facility Quality Meetings (monthly), and Market Financial Reviews (monthly).

Organizational Development and Training will produce new education and training modules as necessary and will be offered through a common on-line learning platform or in person. Onboarding agendas will be modified to reflect the unified goals and objectives of Ballad. Merged project management and Lean/Value Optimization System assets will be allocated by management to select strategic initiatives according to an agreed upon prioritization process.

A new Ballad Health incentive pay system will be implemented which appropriately connects system goals and performance to departmental and individual goals and performance on an annual basis. All levels of the organization will have access to performance Dashboards and progress as appropriate. Directors, managers and supervisors will continue to be critical in developing and monitoring individual performance evaluations, communicating overall performance and identifying action plans when goals are not being met at the individual or departmental level. All management, from front line-supervisors to executive management will be required to attend quarterly Leadership Development Institutes which

[2] Both Wellmont and Mountain States operate on a July 1 to June 30 fiscal year. FY18 begins July 1, 2017 and runs to June 30, 2018. It is anticipated that Ballad Health will also operate on a July 1 to June 30 fiscal year.

include review of system level dashboards, keynote speakers from outside the organization, and several small group break-out sessions designed to transfer necessary information, develop and refine skills, and receive feedback from directors, managers and supervisors.

III. Criteria for Establishing Ballad Health Performance Measures

A. Population Health Measurement

As population health experts have noted, "despite its importance, population health measurement efforts in the United States are poorly developed and uncoordinated."[3] Ballad Health has a tremendous opportunity to lead in the development of measures that support the transition to a value-based population health management system. Ballad Health will seek to develop measures which are:

- Connected to COPA priorities established by the Department of Health;
- Appropriate to the Ballad Health Population Medicine and Community Health Improvement Framework;
- Collaboratively developed with key stakeholders in the Accountable Care Community and the Physician Clinical Council;
- Authorized by the Ballad Board Quality Committee, Finance Committee, and Social Responsibility and Population Health Committee;
- Connected to risk-based agreements with payers;
- Effectively connected to efforts with priority populations;
- Measured from an established baseline or denominator;
- Connected to reliable data resources for accurate and timely measurement;
- Understood by team members and physicians;
- Clearly connected to an aligned or shared system of incentives; and
- Transparent and timely for reporting to all stakeholders.

IV. Challenges and Strategies

Merging performance management processes and deploying best practices across a newly merged organization is not without potential challenges. We have identified the following key challenges and recommend strategies to handle each:

- Challenge: Potential confusion around goals and incentives.
    - Strategy: The transition in the process of setting, communicating, incentivizing and monitoring goals could result in some confusion among management and staff. This confusion could lead to missed organizational goals and missed expectations from staff. Beginning with FY19, all Ballad Health team members will participate in a common incentive plan driven by common Ballad Health performance dashboards. The incentive program and performance dashboards will be communicated through department meetings, Ballad Health team member newsletters, and on-line messages from leadership. Organizational development and training will produce on-line education modules explaining the new incentive plan and the systems annual performance goal. At

[3] Michael Stoto, *Population Health Measurement: Applying Performance Measurement Concepts in Population Health Settings*, 2:4 eGEMs (2014), *available at* http://repository.edm-forum.org/cgi/viewcontent.cgi?article=1132&context=egems.

each quarterly Leadership Development Institute all management will review year-to-date performance against goals, and breakout sessions will be held to address areas of common deficiency. Monthly updates on performance will be made available on the Ballad Health intranet to each employee. This work and the cultural alignment plan will mutually support one another in the transition to becoming a high-performing community health improvement organization.

- Challenge: Resistance to change.
    - Strategy: Systems in most organizations are designed for stability and predictable results, so, at some level, they inherently resist change. If the merger is approved, it will be especially important to demonstrate quick wins related to system redesign. Whether a new Ballad solution is adopted from one organization or the other, or designed de novo, it will be critical to begin the change process immediately and build on momentum. Ballad Health executives will identify opportunities for quick wins and allocate project management and performance improvement assets as necessary to achieve results. These results will be communicated throughout the organization as models for change management in furtherance of the commitment to population health priorities.
- Challenge: Limits on organizational band-width and resources.
    - Strategy: Businesses are always challenged to match internal resources with organizational demands. Hospitals closely monitor labor productivity and routinely flex staff up and down on a daily or even hourly basis. With the intense demands of day-to-day operations, there is often little time available for thoughtful change management or pursuit of innovation. This is one of the key barriers to cultural transformation for Wellmont and Mountain States in the current status quo model. It is also an important reason why the transition to the new population health model is merger specific. Through both organizations' experience with lean management, we have found that an executive level commitment must be made that allows, encourages and rewards efforts to improve - even if there are short term negative effects on productivity. In Mountain States, for example, all Value Optimization System efforts have executive level sponsors who are responsible for securing the time and attention necessary for staff at all levels of the organization to participate in Rapid Improvement Events. Mountain States also actively rewards participation in these efforts through its Annual Quality Awards. Similarly, Wellmont rewards innovation through its Operational Excellence efforts, including the encouragement of innovation through employee driven Kaizen projects[4] aimed at continual improvement in workplace practices and efficiency. These practices will be carried over into Ballad Health.

V. Merger Specific Performance Improvement Opportunities

Creating a unified health system in an overlapping geography with common goals, objectives and performance management structures provides the opportunity to deploy best practices across the organization that would (i) otherwise not be achievable or (ii) require significant duplicative investment over an extended implementation period. Further, it provides the opportunity through derived merger efficiencies to advance priorities for innovation and performance under value-based population health models which require significant financial and human resources.

[4] Kaizen is a form of continuance performance improvement where the main goals are to reduce waste and to increase value through continuous small improvements.

If the merger is approved, the leadership teams focused on the Functional Team areas will shift their focus to deployment of common Ballad Health systems, policies and procedures. These will either be designed anew or adopted from one of the systems as a best practice.[5] The Functional Teams will be supported directly by the merged project management and performance improvement assets of the two systems.

The parties have identified a number of high performing systems and functions within both Wellmont and Mountain States that may be replicated in Ballad Health. These include:

A. Mountain States Systems/Functions

1. Mountain States Value Optimization System

Mountain States partnered with Simpler Consulting in 2012, for the purposes of creating transformational change through lean principles in line with the Institute for Healthcare Improvements Triple Aim Initiative.[6] Successes have been realized in quality, clinical performance, and financial (operational) performance across the system. To date, Mountain States has recognized dramatic improvements through over 100 value stream efforts resulting in savings in excess of $75 million and improved clinical performance.

Consistent adherence to a proven process is resulting in continued improvements and performance breakthroughs. Relying first on Simpler for on the job teaching and training, internal subject-matter-experts have now been developed to accelerate the spread of the system and tools across Mountain States. Team member education has been paramount to the success through the completion of education on LEAN methodologies and tools to be used in events and in daily standard work.

Wellmont began process improvement work under the Toyota model in 2006 and has continued to advance that process in a variety of ways since, significantly resourcing and ramping up LEAN training in 2015. Since the program is in its initial stages, focus has been on leadership training working with the Business Excellence Institute, a program noted for success in achieving and replicating Malcolm Baldridge criteria and systems. Together, the stage is set to expand these efforts across Ballad Health. Because of the number of lean experts who have been developed inside Mountain States, the existence of well-established methodologies, and the on-going assistance of Simpler coaches (sensei), the Mountain States Value Optimization System model is well positioned to be expanded into legacy Wellmont clinical business units at a lower cost and more rapid pace than could be done alone. An outside merger would not provide the locally available lean resources that Mountain States can bring to Ballad Health.

2. AnewCare Collaborative

Organized under Mountain States' subsidiary Integrated Solutions Health Network, AnewCare Collaborative performs network management, case management, analytics, quality management and auditing, and practice performance improvement services on behalf of the participating physicians in the collaborative's current Medicare Shared Savings Program ("MSSP") and Amerigroup TennCare contracts.

[5] *See* Response #7, Exhibit 7.1.

[6] SIMPLER, http://www.simpler.com/p/about-us.

These agreements currently cover approximately 14,000 lives in a Track 1 Medicare Shared Savings Program ACO and 17,000 lives under an Amerigroup TennCare Contract. Approximately 13,000 of the total 31,000 lives are attributed to Mountain States Medical Group Physicians, the remaining are attributed to independent physicians throughout the region. AnewCare is one of a limited number of MSSP ACO's that received shared savings payments in each of the first three years of the program.

Wellmont operated an MSSP program for one year before the decision was made to shut the program down. At that time the program covered around 9,000 lives. The addition of these lives to the AnewCare current population would significantly reduce the per member cost of providing ACO services by spreading current overhead and would also leverage proven network management, case management, analytics, quality management and auditing, and practice performance improvement services for the benefit of Wellmont physicians and their attributed MSSP patients. These Wellmont lives could be added in September of 2017 during the annual practice attribution process. This would only happen with an in-market merger.

B. Wellmont Systems/Functions

1. Wellmont Health System Epic Optimization

After an Epic Electronic Health Record Implementation in 2014, Wellmont shifted focus to optimization and has been working to get the full value from this advanced clinical information platform. In 2016, Wellmont achieved Level 8 out of 10 in its use of the Epic platform for the health system's electronic health record. Wellmont was one of only eight Epic users in the world to attain at least this level as part of the software company's Gold Stars program. In reaching this status, the health system has implemented 87 percent of Epic's functionality just two years after instituting the platform across the organization. Wellmont is working diligently on securing Level 9, a status earned by only four users across the globe.

The organizational expertise, as well as the system set-up and design parameters and clinical protocols already worked through by Wellmont, would significantly reduce implementation time and costs at legacy Mountain States facilities and practices should Ballad choose Epic as their common EHR platform. While merger with an outside organization could possibly bring the experience to Mountain States necessary for a planned EHR conversion, it is unlikely to be as sophisticated and successful as that which Wellmont could provide, as evidenced by the achievement levels noted above.

2. Wellmont CVA Heart Institute Clinical Process Innovation and Research Combined with Mountain States' Investment In Clinical Research Is Powerful and has the Potential to Create a Compelling New Competitor In the National Research Space.

The Wellmont CVA Heart Institute has received significant national recognition for clinical and process improvement research related to interventional cardiology. For example, three times in one year, an internationally renowned and respected interventional cardiologist with the Wellmont CVA Heart Institute has been published in the country's premier medical journal. Chris Metzger, M.D., recently co-authored an article about a nine-year study called ACT 1, a landmark clinical trial in which the heart institute was the No. 1 worldwide enroller of patients. The heart institute has served as the No. 1 or No. 2 enroller in the United States and across the globe in at least 25 top research trials, including being the current leading enroller in four major trials. The heart institute now has about 25 studies that are actively enrolling patients or soon will. Similar research activity

and an internal Institutional review board drive efforts for 80 active oncology research trials within Wellmont Cancer Institute.

Mountain States currently has more than 60 clinical trials active within the system, and utilizes the IRB associated with East Tennessee State University. The merger of the research programs will have several benefits available only through the merger. First, the current clinical trial patient base will be greatly expanded – helping Ballad Health better meet clinical trial enrollment goals and by opening up clinical trials previously available only to patients of Wellmont or Mountain States. This will enable Ballad Health to become more competitive in attracting partnerships with leading institutions and funding internationally to bring research trials to the region. The region is not as attractive to these potential partners if each system is acting independently with lower volumes and without the benefit of nearly 100,000 discharges and millions of patient contacts supported by a common IT platform and data and a partnership with local research faculty. These research trials will be a benefit to our patients. Second, by merging existing resources, and taking advantage of the sizeable investment made by Wellmont in administrative infrastructure, the administrative costs of the research enterprise will decrease relative to the amount of research being conducted. Ballad Health will devote the resources of the Wellmont investment into cardiovascular research into expansion to the entire population of the combined system, and will integrate the robust trials being conducted by Mountain States with the Wellmont patient population and administrative infrastructure. The population variety and volumes represented at Ballad Health will be incredibly attractive to organizations conducting novel research, and the existing infrastructure scaled across Ballad will draw not only new clinical trial opportunities but also opportunities for funding of new translational research for population health management and community health improvement strategies (especially those impacting rural populations) by working with academic partners.

Ballad Health
7. Cultural Alignment Plan

Executive Summary: A strong organizational culture focused on the Triple Aim will be essential to Ballad Health's organizational performance. To achieve these aims under the merger, first, Ballad must integrate and align the two existing health system cultures. A cultural audit of the two organizations was conducted during due diligence which exhibited that the two cultures are very similar and that the two workforces and leadership teams should mesh well.[1] Second, the integrated Ballad Health organization must be continually educated, incentivized and measured to move from a traditional health care delivery system designed to produce volume toward a community health improvement organization culture centered on the Triple Aim. Both elements will require a concerted focus in the first twenty-four months of the merger and thereafter.

I. Cultural Alignment Plan.

Mergers and acquisitions almost always involve some level of transformational change, but health system mergers involve particularly complex human organizations where culture is critical to mission.[2] Leaders from both Wellmont and Mountain States have been involved in mergers in the past and not only understand the importance of success with cultural alignment and transformation but also have direct experience with it. For Ballad Health's organization to be successful, it will be essential for Wellmont and Mountain States to fuse their existing cultures into a new, strong organizational culture focused on the Triple Aim.

A. Planning for Cultural Alignment.

Mountain States and Wellmont recognized early in their discussions that cultural integration would be a key component to a successful merger. Beginning with the Term Sheet executed between the parties in April, 2015, the leaders of the two organizations began the important work of assimilating a joint board, a joint management team, and establishing a culture in the new organization that would bring the two organizations together as one.[3]

1. Shared Vision and Guiding Principles.

As a first step in bringing the two systems together, the Wellmont and Mountain States' CEOs and Board Chairmen articulated their Shared Vision and Guiding Principles to facilitate the merger as part of the Term Sheet executed on April 2, 2015.[4] The Shared Vision and Guiding Principles were then adopted unanimously by both the Wellmont Board and the Mountain States Board and incorporated into the Master Affiliation Agreement and Plan of Integration executed by the Parties on February 15, 2016. This

[1] This study was submitted during the application process, and we will outline the essential elements for integration in this document.
[2] Marty Stempniak, *The Art of Blending Cultures,* HOSPITALS & HEALTH NETWORKS, July 8, 2014 ("There's an emotional side to an integration of two organizations that hospital leaders can't ignore. 'People are born and die and miracles occur in these places every day, and it happens right before the eyes of the employees and physicians.'"), *available at* http://www.hhnmag.com/articles/4117-the-art-of-blending-cultures.
[3] *See* TN DOH Response April 22, 2016, Exhibit 6 - Copy of the Nonbinding April 2, 2015 Term Sheet.
[4] *See id*.

Shared Vision outlines the Parties' intent to come together as equal partners to develop a brand new health system for the region with a new leadership structure, a new board, a new name, and a new kind of vision. The Guiding Principles set forth the Parties' commitment to patients, physicians, employees, clinical services and quality, population health, and management.

2. The Joint Board Task Force.

After the Term Sheet was executed, Wellmont and Mountain States formed the Joint Board Task Force to oversee the integration of operations and cultures.[5] The Joint Board Task Force is a committee of the two boards acting as a liaison and providing information and guidance during the transaction process. Wellmont and Mountain States each nominated an equal number of their existing board members to become members of the pre-closing Joint Board Task Force and the CEOs of Wellmont and Mountain States each serve on the Joint Board Task Force. The members represent a cross section of regional and physician leadership from the community, incorporating those with experience in governance, administration, business and strategy – both in health care and in the business community. The Joint Board Task Force has met regularly since April, 2015, to guide the pre-closing activities, including the evaluation of cultures, a plan for aligning operations and cultures, and establishment of the mission and vision for the new system.

3. The Integration Council.

In addition to forming the Joint Board Task Force, the parties also established an Integration Council responsible for overseeing the pre-merger planning. The Integration Council is made up of an equal number of executives from Wellmont and Mountain States' leadership teams. This group has been charged with the undertaking a comprehensive analysis of the clinical, operational and financial functions of Wellmont and Mountain States. The Integration Council has been meeting regularly to analyze the capabilities of both organizations and prepare plans for operational and cultural alignment once the appropriate approvals have been received. Among other tasks, the Integration Council was charged with hiring a consultant to conduct a cultural assessment of the two organizations. The Integration Council is also responsible for guiding the work of seventeen functional teams made up of leaders from each organization who are formulating plans to outline the work that must occur to prepare for the merger and the work that must occur immediately after the merger. These teams are also considering the functional steps needed to bring the two operational cultures together effectively and represent each functional area of the new health system including finance, human resources, supply chain, IT, and others.

4. The Cultural Assessment.

In order to better inform the integration of the two organizations from a human relations and cultural standpoint, the Parties engaged the Hay Group, a third party consultant, to conduct a culture audit of the two organizations. The internationally recognized consulting firm, which focuses on improving organizational effectiveness, was engaged to look at areas of alignment between the systems that would enable the proposed merger, the areas of differences between the systems that might impact the proposed merger, best practices within each system that might be leveraged in the merged

[5] *See* Press Release, Wellmont Health System, Mountain States Health Alliance Name Members of Joint Board Task Force, *available at* http://www.wellmont.org/News/2015/Wellmont-Health-System-and-Mountain-States-Health-Alliance-Name-Members-of-Joint-Board-Task-Force.aspx.

organization, the compatibility and alignment of each system with the Shared Vision and Guiding Principles of the proposed merged entity, and strategies to facilitate success of the proposed merger.

While the specifics of that culture audit remain confidential, the Hay Group found that there is considerable alignment between the systems that will serve to greatly facilitate the merger.[6] Specifically, they found that the current mission, vision and values of Wellmont and Mountain States overlap and are highly compatible. Additionally, after reviewing the Share Vision and Guiding Principles, the Hay Group determined that the fundamental elements of the Shared Vision and Guiding Principles were embodied in Wellmont and Mountain States' existing cultures. For example, both systems already place great emphasis on patient focus and quality, which is a foundation of the Shared Vision and Guiding Principles. The Hay Group believes these alignments will serve to greatly facilitate the merger.

B. <u>Alignment of the Cultures.</u>

If the merger is approved, specific steps will be taken to align the cultural identities of the two organizations, including establishment of a new competency based governing board with of new, independent board members with experience in integration, selection of executive leadership, implementation of a new system-wide Physician Clinical Council, and implementation of a single information technology platform to implement common clinical standards for improvement of patient quality and promote system-wide communication and clinical cultural integration.[7]

1. New Governance.

Cultural alignment starts with the governing board. Ballad Health's Board of Directors will be composed of board members from both Wellmont and Mountain States who have now been working together for several months on merger implementation planning as the Joint Board Task Force. The new Board of Directors which will have equal representation from Wellmont and Mountain States, as well as two new independent, jointly appointed members. The board will also include a lead independent director who will be a Wellmont board appointee who will work with the board in coordination with the executive chairman. This is a best practice model frequently used by companies who have an executive chairman. The president of East Tennessee State University will also serve on the Board of Directors as an ex-officio non-voting member of the Board because of the significant emphasis on the development of an academic medical center model in partnership with Ballad Health and ETSU.

The design of the new governing Board for the merged organization was completed with the assistance of Accord Limited, an independent consulting group that works with health system boards across the United States. Accord reviewed the existing governance cultures of both Wellmont and Mountain States and considered these cultures in the context of the Shared Vision and Guiding Principles. The specific details of the report remain confidential, but Accord found that the two boards have a good deal in common.[8] Accord encouraged the two boards to begin working together through board education, trust building, team-building, utilization of best practices, and to focus on the new shared vision as this will be the key success factor for the Ballad Health Board.

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[6] The results of that culture audit were provided to the Tennessee Attorney General's Office under CID on June 16, 2016.

[7] Application for Certificate of Public Advantage, State of Tennessee, Section 11.h.iv at 78-80.

[8] The results of that governance assessment were provided to the Tennessee Attorney General's Office under CID on June 16, 2016.

Both Wellmont and Mountain states have agreed that the new board will embrace evidence-based practices for good governance as recommended by Accord. These practices are enumerated in the organization's new bylaws[9] and further described in the governing policies that are currently being developed.

2. New Management Team.

Research indicates that leadership is the most important driver of employee engagement. During periods of transition, employees look first to leaders for guidance about how to react and behave, for motivation, and for focus.[10]

Ballad Health will be managed by an executive team with representatives from both organizations, including Executive Chairman/President Alan Levine (currently Mountain States' CEO) and CEO Bart Hove (currently Wellmont's CEO). The roles of each are clearly defined.[11] The CEO will have full responsibility for daily operations of Ballad Health, and the COO, CFO and CMO will each report directly to the CEO. The CEO will report directly to the Executive Chairman/President of Ballad Health. The Executive Chairman/President will chair the governing board and will have overall responsibility for the strategic direction of Ballad Health. This position will be supported by the departments of strategy, marketing and communications, government affairs and the population health. The Executive Chairman/President will be evaluated by the Ballad Health governing board.

3. New Culture.

Integrating and redefining the culture and corporate values of merged organizations is essential for the integration process.[12] The board, executives, and leadership teams of Mountain States and Wellmont are fully committed to the concerted work of establishing a new Ballad Health culture, incorporating the best of the two existing cultures and a new common vision. Central to this has effort been the uniform agreement and support of the Shared Vision and Guiding Principles unanimously approved by both boards at the beginning of the discussions between Wellmont and Mountain States.[13] Already, the Joint Board Task Force (which will become the Ballad Health board) and the Integration Council have successfully formed key elements of Ballad Health and are actively conducting in-depth integration planning through 17 functional teams.[14]

The selection of a new name and new mission, vision, and values statements will help ensure evolution beyond the two existing cultures to form a new, cohesive Ballad Health culture and way of doing business. The newly established "Ballad Health" brand, Mission, Vision and Values which will focus each

[9] *See* Exhibit 8 to the April 22, 2016 DOH Response (NewCo, Inc. Bylaws).
[10] *See* Richard M. Able, HUMAN CAPITAL INSTITUTE, *The Importance of Leadership and Culture to M&A Success* (January 16, 2007), *available at* https://imaa-institute.org/docs/m&a/towersperrin_09_the%20importance_of_leadership_and_culture_to_M-and-A_success.pdf.
[11] *See* Exhibits D-2 and D-3 to the Cooperative Agreement (provided as Exhibit 11.1 to the Application, *supra* n7).
[12] *See* Aliah D. Wright, SOCIETY FOR HUMAN RES. MGMT., *Successful Mergers Integrate Cultures* (June 30, 2010), *available at* https://www.shrm.org/hr-today/news/hr-news/pages/successfulmergersintegratecultures.aspx.
[13] *See* Exhibit B to the Cooperative Agreement (provided as Exhibit 11.1 to the Application, *supra* n7).
[14] *See* attached Exhibit 7.1 - Description of the Functional Teams.

team member on the uniqueness of each patient and community we serve and how we engage with them—an orientation to listen, understand, and respond effectively to the story of each person we serve, including the spectrum of factors that impact health outcomes. We have placed this value at the center of our brand and must ensure that the experience of those we serve matches the brand promise.

Ballad Health intends to ensure that pursuit of the Mission, Vision and Values is embedded in the recruitment, hiring, onboarding, evaluation, development and incentives of Ballad employees. Each team member should develop an understanding of their unique role and our collective approach to Ballad's foundational identity and relate their individual performance to the system's mission, vision, and values.

For this reason, it was determined that the employees of the new organization should participate in identifying the core values under which they would pursue their work and hold themselves and each other accountable. This process will begin upon approval of the merger where will create a set of initial rallying activities and ask each team member and physician to contribute directly to defining our collective values and relating them to our mission, vision, and guiding principles. Human resources, organizational development, marketing/communications, and leadership teams will help to facilitate this effort and cross organizational learning and relationship building will be emphasized. The results will be ratified by the newly formed governing board of Ballad. An intentional set of activities and engagements will follow a kick-off event through the first twenty-four months and after as we continually seek to reinforce the culture we need and relate it to our engagement with one another, with patients, and with the communities we serve.

4. New Clinical Leadership.

Transformation to an integrated delivery system is a key element of the merger, but it will be essential to align the clinical culture across the new organization for the transaction to realize this goal.

Ballad Health is already working to establish a Physician Clinical Council charged with setting common standards of care, credentialing standards, quality performance standards and best practices. The initial Clinical Council will equally represent physicians whose primary practice venue is currently Wellmont or Mountain States as well as large independent practices and a regional mix. Medical staff leadership will nominate representatives. The charter for this group and a description of its membership criteria is attached.

Ballad Health will also adopt a Common Clinical IT Platform that will allow all providers 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. Use of this common platform will immediately break down inter-facility barriers in establishing uniform practice protocols in the hospitals across the system and in setting a common clinical language for all medical staff members and hospital staffs. This combined with the work of the Physician Clinical Council will support a common culture of quality expectations and performance across the system.

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

C. Cultural Transformation to a Community Health Improvement Organization

As noted in the Overview, achieving integrated care and the transition to a community health improvement organization will require changing the health-care culture and how clinicians think about care delivery. We believe that our team members and physicians, throughout the organization, desire to keep each patient healthy and live in a community that is healthy and thriving. The design of our national health system, however, from the legacy emphasis and fixed cost of hospitals, to the still prevalent nature of the fee-for-service payment, has trapped them in a system where everyday workflow largely encourages volume over value. Given the chance, as well as the necessary tools, training and incentives, we believe that team members and physicians alike will not only embrace, but help drive, Ballad's efforts to become a Community Health Improvement Organization.

How can we, through each key interaction, be cognizant of our desire to achieve the Triple Aim to be efficient, high quality, and accessible/highly engaged and responsive and how can the culture we create internally shape the culture of our community? Some of the key elements needed to ensure this shift in emphasis are included below:

- Elicit a shift from what it means to be a health care system to what it means to be a health improvement organization.
- Impart an understanding of how the actions we take as health improvement professionals (vs. health care professionals) impact the cost of care, quality of care, and accessibility of care for the people and communities we serve, including underserved populations. The role belongs to everyone.
- Impart an understanding of the spectrum of factors that contribute to health outcomes and encourage each team member to be aware of and interact with those we serve around behavioral and social determinants of health.
- Embed protocols or mechanisms of engagement in clinical settings that emphasize prevention activities such as screenings and immunizations as well as critical conversations about behavioral contributors such as diet, exercise, tobacco use, and substance abuse as well as embedded screenings for social needs and connectivity to social resources.
- Enact new job responsibilities, exemplified through leadership, that align how we spend our time with the commitments we have made. We will be healthy examples through our dining services, vending machines, empowerment of exercise programs, allocation of resources, and service in schools and community organizations—as reading tutors or through the provision of water bottle filling stations, for example.
- Intentionally move key activities outside of the clinical setting to the community setting to increase accessibility and raise awareness. In addition to mobile strategies and enhanced telemedicine strategies, we should be embedded in schools, religious organizations, businesses, and neighborhoods to engage, educate, and deliver resources.
- Ensure that the goals set forth in our COPA commitments are understood across the organization and spend time with each department and team member connecting their work to the COPA outcomes we seek to achieve, so that goals are owned by each person in the organization to drive collective impact.
- Demonstrate leadership and re-orient our corporate citizenship to exemplify a changing orientation internally and to encourage other organizations to join us in partnership. This will play out through our establishment of a multi-sector approach to the Accountable Care

Community (which is designed to break down barriers) along with concerted engagement with non-health sectors such as education, government, and business through the extension of expertise and resources.

- Work with both employed and independent or community physicians to achieve alignment of vision and clinical approaches around the Triple Aim and to influence practice patterns and ultimately align incentives supported by a clinical alignment, a common IT platform, the use of a common HIE, and the leadership of the Physician Clinical Council.
- Create integral partnerships with payers and businesses to align payment systems and incentives with community health and population medicine objectives and to reach populations.
- Ensure that these strategies and their expected outcomes are reflected clearly in our strategic plans and budget allocations.
- Use effective internal and external communications strategies to drive the desired culture and exemplify its development through success stories.
- Include this list in the ongoing work of the Population Health and Social Responsibility Committee of the Board as they seek to achieve compliance with our COPA commitments.

II. Challenges and Strategies

We recognize that challenges will exist both in the alignment of the two existing cultures and in the move to a shared culture of community health improvement, and we have identified the following strategies to address each of these challenges:

- Challenge: Underestimating the importance of culture and not emphasizing it significantly enough.[15]
    - Strategy: To overcome the risk of failure, leaders must focus on understanding and developing the new entity's culture. If leaders show up unaligned, the two merging companies will be unaligned. Ballad Health's leaders have already begun the work needed to come together as “one team” through aligning their vision and strategy for the new health system. In April, 2015, the parties announced formation of the Integration Council, which is made up of executive and physician leaders from both systems to further develop plans in the best interest of clinical quality and the patients served. The Integration Council has been meeting regularly to oversee the merger analysis and preparations, including the culture audit conducted by the Hay Group, and plan for the integration of the proposed combined system. As evidenced by the work done to date, the Parties understand the culture of the combined organization will set the tone for Ballad Health's success and have committed significant resources early in the process to ensure that the cultures are aligned efficiently and effectively.

- Challenge: A mismatch of cultures at the local level can cause challenges across the system.
    - Strategy: Even when merging organizations' purposes are similar, their operating procedures, or "how things get done," can vary significantly. The leaders of Ballad Health recognize that it will be crucial to understand how hospitals and operating

[15] *See* Brooke Fernandez & Andrew Giger, *Three Prescriptions for Successful Healthcare Mergers*, GALLUP BUS. J. (Nov. 19, 2014) (*stating* "Myriad factors can lead to M&A failure, but cultural mismatch is one of the most frequently cited reasons."), *available at* http://www.gallup.com/businessjournal/179486/three-prescriptions-successful-healthcare-mergers.aspx.

divisions within the two organizations achieved results prior to the merger, so a plan may be developed for integrating these procedures and best practices going forward. The cultural audit performed by the Hay Group has helped identify areas where cultural identity and consistency could be improved. The Integration Council intends to use this information, along with their deep knowledge of their own facilities and operating divisions to address areas at the local level that may need additional attention or communication.

- Challenge: Keeping quality of care front and center.
    - Strategy: The importance of clinical quality and performance improvement can often get overshadowed in healthcare merger planning. [16] To ensure that the culture of quality remains a primary focus throughout the planning and integration process, Ballad Health has given both employed physicians and independent physicians an important role in post-closing integration as members of the Physician Clinical Council. The Council will be charged with setting common standards of care, credentialing standards, quality performance standards and best practices. Their work will help drive the transformation to a community health improvement organization and to ensure that quality of care remains the central focus of the Ballad Health culture.

- Challenge: Setting the right pace for integration of cultures.
    - Strategy: Cultural integration and operational integration has to happen at a thoughtful and deliberate pace.[17] If an organization moves too slowly, it could fail to achieve its potential synergies, but if it moves too quickly, it could lose key people along the way. In an effort to address this, Ballad Health has established functional teams made up of leaders from each organization who are formulating plans for the work that must occur in each functional area to prepare for the merger and the work that must occur immediately after the merger. These teams are also considering the functional steps needed to bring the two operational cultures together effectively and the timeline needed to do so. By planning for the specific timelines needed for integration in each functional area, Ballad Health will be able to manage the cultural process change to an integrated delivery system in a systematic and organized way.

III. How are these activities merger specific?

While payers' movement towards Value Based Contracting will continue to drive the health systems towards assuming more risk for the health of populations, the potential for truly managing a population that is not split by two competing health systems, resourced as a result of synergies, and actively supervised under a COPA can only occur with the proposed in-market merger of Wellmont-Mountain States merger. In the current environment, the two health systems are exploring more value-based purchasing or pay for performance arrangements and are embracing those opportunities to expand payment paradigms and test capabilities. However, two important exercises have demonstrated that short of a merger of the two systems, movement toward higher levels of risk is unlikely. First, Cigna attempted to focus their network several years ago to derive higher quality outcomes at lower costs—

[16] *See* Maggie Van Dyke, *When Two Cultures Merge: Creating a New and Improved Healthcare Organization,* HEALTHCARE EXEC. MAG. 21 (Nov./Dec. 2015), *available at* https://www.towerswatson.com/en-US/Insights/IC-Types/Reprints/2015/when-two-cultures-merge-creating-a-new-and-improved-healthcare-organization.
[17] *See id*.

including only one of the regional systems in the network. The experiment did not succeed in large part due to pressure from employees of businesses with Cigna to expand the network to include both health systems and their related physicians, hospitals, and specialty services. This experiment confirmed that people who live and work across the region are more likely to support population health systems as willing participants if they include both health systems—a situation which is unlikely if the two systems remain separate and most likely participate in diverse value-based arrangements. Second, Mountain States' venture to provide insurance through Crestpoint revealed that the population under management needed to be significantly larger in order to absorb the actuarial risk that would result in success. Even though Ballad Health has no plans to develop an insurance product, the alignment of risk-based population health incentives and effective management of risk being placed on the systems by payers are similar. In addition, a larger population is needed to support the cost of infrastructure essential for analytic capabilities, case management, care coordination, and administrative management functions. Though expert opinions vary on the size population needed for the effective assumption of significant risk, both Mountain States and Wellmont are reluctant to take on the assumption of significantly more risk independently because neither has envisioned a sound fiscal model or can afford the needed infrastructure separately. Under the merger, however, risk can be spread over a larger population and resources can be developed and deployed more efficiently.

The creation of a new health system with a new name and new mission, vision and values will create a pivotal moment for cultural transformation to occur and for expectations to be reset, not only within the health systems themselves, but within the communities. Many leading businesspeople and community leaders view the merger as a critical opportunity to break down walls which heretofore have kept communities in the region from collaborating on education, economic development and social programs.

Exhibit 7.1

Description of Functional Teams

The Parties recognize the vital role they play in their local communities. They understand the importance of assuring that the integration of Mountain States and Wellmont into Ballad Health occurs smoothly with no disruption to critical services. For this reason, the Parties worked diligently to develop a roadmap for integration planning that would assure their readiness to operate as one entity once all necessary regulatory approvals were obtained.

Until all such approvals are obtained, the Parties remain competitors. Consistent with this fact, the Parties' integration planning framework was developed in close consultation with legal counsel to assure full compliance with the antitrust laws.

The Parties' integration planning framework is organized around a joint Integration Council. The Integration Council is comprised of senior management from each health system, including each system's general counsel. The members of the Integration Council are responsible for planning key operational functions for post-closing implementation. The Integration Council established 15 Functional Teams are responsible for planning in discrete operational areas, including:

- Clinical council
- External affairs
- Finance
- Governance
- Hospital operations
- Human resources
- Information technology
- Managed care
- Physician operations
- Post-acute operations
- Quality
- Research and academics
- Retail operations
- Strategy, and
- Supply chain

Each Functional Team has a detailed project plan with pre-close tasks designed to assist with planning of key operational functions for post-close implementation. The project plans were reviewed and approved by counsel and the Integration Council.

The integration planning teams held a kick-off meeting in March 2016 to outline their scope of work. Antitrust counsel advised the Functional Teams about the antitrust laws that apply to integration planning activities. The Functional Teams began meeting on a bi-weekly basis in September 2016 once the Applications were deemed complete in both Tennessee and Virginia. Antitrust guidelines are read before every Functional Team meeting and a representative of one of the legal departments participates in each meeting.

Ballad Health
8. The New Clinical System

Executive Summary: In this response, we describe the proposed care team models that will be developed within Ballad Health, we discuss Mountain States and Wellmont's current experiences with care teams, we identify the strategies that will be utilized to address challenges encountered during implementation, and we explain how the merger would facilitate these new care models.

I. A Proposed Care Team Model

According to the Institute for Healthcare Improvement:

> *"The current infrastructure for primary care in the US is not sufficient to meet the population management needs of a primary care patient panel. Researchers have estimated that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 primary care patients (similar to the average US primary care panel of 2,300), plus 10.6 hours to adequately manage this panel's chronic conditions. If you include the estimate that it takes 4.6 hours per day for acute care, this adds up to 22.6 hours per day. It's also been estimated that an average of only 54.9% of adults in the United States received recommended care in each of those areas.* ***It is not possible to achieve improved population health without substantial (versus incremental) change****."*[1]

Efforts to build a better care model have existed for some time. For example, in the 1990s, with input from national experts and support from the Robert Wood Johnson Foundation, The MacColl Center for Health Innovation produced the Chronic Care Model, which identifies the essential elements of a health care system that encourage high-quality chronic disease care. "These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise."[2]

Over time and with successful application of the CCM, it became clear that modifications were necessary for the model to be successfully applied in a population health context. The Expanded Chronic Care Model (ECCM) displayed in Figure 1 now integrates population health promotion into *prevention* & management of chronic disease. There is now more emphasis on supporting people and communities

[1] Cindy Hupke, INST. FOR HEALTHCARE IMPROVEMENT, *Team-Based Care: Optimizing Primary Care for Patients and Providers* (May 2014), *available at* http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?list=0f316db6-7f8a-430f-a63a-ed7602d1366a&id=29.

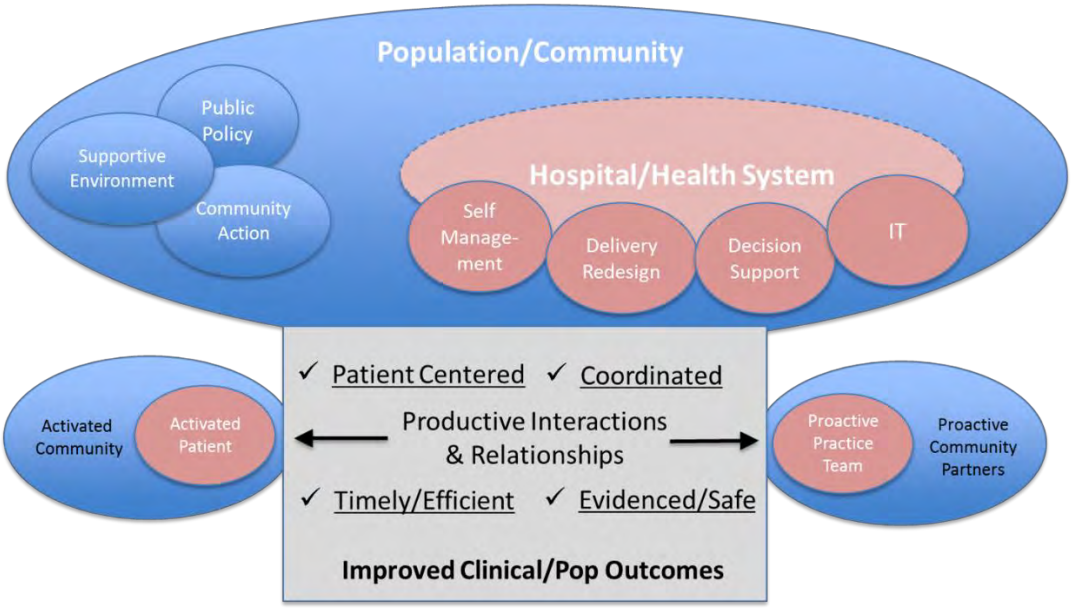
[2] GROUP HEALTH RESEARCH INST., THE CHRONIC CARE MODEL, *available at* http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18.

to be healthy with greater focus on social determinants of health as well as delivering high-quality healthcare services.[3]

Although each component of the model deserves discussion, the proactive practice (care) teams' interaction with proactive community partners and activated patients and community is core to the ECCM's success. A widely accepted definition of "team-based care" is:

> *"The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable."*[4]

Figure 1: Expanded Chronic Care Model



Barr, Robinson, Marin-Link, Underhill, Dotts & Ravensdale (2002)

Productive interactions between a proactive practice team and the activated patient are crucial. In order to achieve success, the proactive practice team must have the information, decision support and resources need to deliver high quality care, and the activated patient must have the motivation, information, skills and confidence to effectively manage his or her health. A productive interaction should include:

- assessments of clinical status, self-management skills and confidence (possibly using a valid patient activation measure survey);
- individualizing of clinical management potentially using stepped protocols;
- a care plan built by collaborative goal-setting and problem solving; and

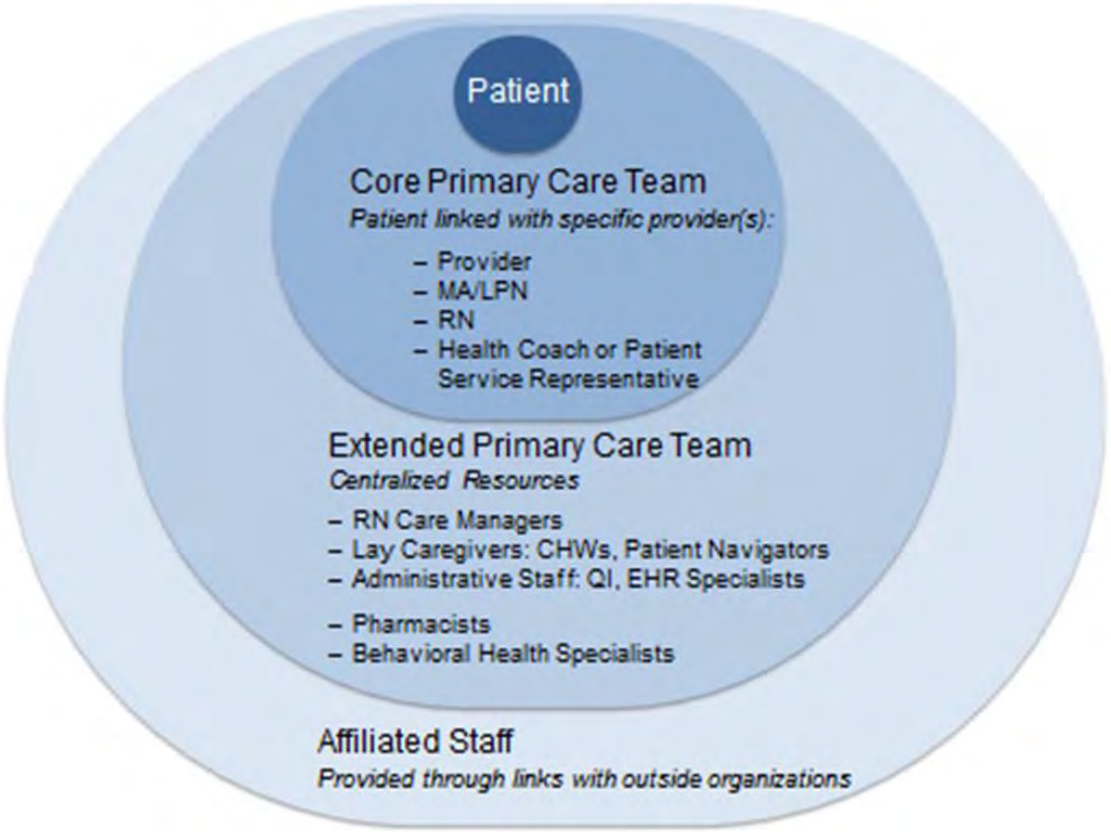
[3] Kathryn Kash, Jefferson School of Population Health, Address to the 11th Population Health & Care Coordination Colloquium, Pre-Conference Boot Camp (March 14, 2011) (slideshow), *available at* http://www.ehcca.com/presentations/pophealthsummit1/kash_pc.pdf.

[4] MD Naylor, et. al, *Team-Based Primary Care for Chronically Ill Adults: State of the Science, Advancing Team-Based Care* (American Board of Internal Medicine Foundation 2010).

- sustained follow-up.[5]

It is important to recognize the expanded definition of the Primary Care Team, which is necessary to achieve both better population health outcomes and individual clinical and functional outcomes. The ECCM specifically adds the support of proactive community partners to the clinical practice. Figure 2 depicts a model for this expanded concept of the Primary Care Team developed as part of the MacColl Center *Learning from Effective Ambulatory Practices (LEAP)* project funded by the RWJ Foundation. A core team is collectively responsible for a defined patient panel linked with a specific provider, clinical assistants, RN, health coach, and front desk staff. This core is supported by extended team members who serve as shared resources available to patients of multiple core primary teams. An additional outer layer includes staff not employed by the practice but proactively included as part of an individual's care team through case management plans and formal links with community partners.[6]

Figure 2: The LEAP Primary Care Team Conceptual Diagram



[5] Kathryn Kash, Jefferson School of Population Health, Address to the 11th Population Health & Care Coordination Colloquium, Pre-Conference Boot Camp (March 14, 2011) (slideshow), *available at* http://www.ehcca.com/presentations/pophealthsummit1/kash_pc.pdf.

[6] ROBERT WOOD JOHNSON FOUNDATION: IMPROVING PRIMARY CARE, *The Primary Care Team: Conceptual Diagram* http://www.improvingprimarycare.org/sites/default/files/topics/Team-Step2-Care%20Team%20Conceptual%20Diagram-DC.pdf.

Both Wellmont and Mountain States operate NCQA Patient Centered Medical Home (PCMH) practices, which provide a baseline standard for a care team that is focused on better-coordinated management of patients. This certification was pursued over time as payers increasingly incentivized or required this, or similar, certification. NCQA PCMH certification has, over time, required more components of the ECCM with an emphasis on team-based care, focusing the patient as the center of care, consideration of social determinants of health, behavioral health integration, and care coordination and follow up with external support organizations. A number of roles listed above in the extended primary care team are increasingly utilized, including RN care management, patient navigators, QI specialists and pharmacists.

Both health systems are pursuing further implementation of the ECCM and the LEAP Primary Care Team model. Several examples are listed below.

A. CareScope 360

In anticipation of the merger, Mountain States and Wellmont applied for and received a $205,000 grant from the Virginia Health Care Foundation to provide care coordination and linkages to community resources for uninsured individuals with high utilization of the emergency department (ED) and at least one hospital admission at either Norton Community Hospital in Norton, VA (Mountain States Health Alliance), or Lonesome Pine Hospital in Big Stone Gap, VA (Wellmont Health System). The goal of the grant is to reduce ED utilization rates and avoidable hospital admissions by improving health status through better identification and management of medical needs and social barriers before they reach crisis stage. The timeframe is June 1, 2016, through November 20, 2017, and 175 individuals are expected to be served.

CareScope 360 takes a "360 degree view" of a patient's strengths and needs, both medical and social. The target population for this project is uninsured individuals with high utilization of the ED and who were ultimately admitted to the hospital on at least one occasion. Operating at the core of the program are dedicated care coordinators and one community health worker who work to connect each individual to primary care, behavioral health and social support services.

Our grant partners are the Health Wagon for primary care services, the Wise County Community Service Board and Frontier Health for behavioral health needs, and the Virginia Department of Health's Lenowisco Health District for training, education and other support for the community health worker. In addition, we are now working with Mountain Empire Older Citizens Area Agency on Aging (MEOC) to help with transportation issues with the CareScope 360 participants, and the Stone Mountain Federally Qualified Health Center (FQHC) as a second primary care option that may be closer to their homes.

Care coordinators focus on identifying needs and creating a plan of care, and the community health worker works to facilitate the plans of care. Individuals meeting the selection criteria are contacted by the care coordinators and offered the chance to opt-in to the program. Those who can be reached and eventually enroll are screened for their unmet social needs (such as food and housing insecurity, domestic violence, lack of adequate transportation, etc.) and level of patient engagement in their own care. A second screening determines if the patient has a primary care physician, if they need medication assistance, and if they need more in-depth education on any current or chronic health conditions. Patients also receive a behavioral health screening to determine if a referral to Frontier Health is appropriate. Finally, patients will be

screened for eligibility for Medicaid or for enrollment into a health plan on the Health Insurance Marketplace.

B. Community Paramedicine

Mountain States and Washington County EMS are currently exploring the creation of a community paramedicine program that would provide home-based care and well checks for individuals who are frequent ER utilizers but who do not qualify for other forms of home health. The program would involve EMS, ER, home health, social work, and case management and would seek to improve health outcomes and decrease ER/hospital utilization by having specially trained paramedics conduct regular home visits to provide full body assessments, wound care, medication administration, blood pressure and blood sugar checks, education and referrals to community resources, and emergency action as needed.

Referrals to the program would be made through the hospital ER. Patients in the program would be frequent ER utilizers who do not have primary care, do not qualify for other forms of home health, and/or have other risk factors such as food or housing insecurity. Weekly case conferences would evaluate patients' progress, and other community agencies and partners would be looped in where appropriate, including the ETSU Community Health Center, housing services, food banks and others.

Paramedicine makes sense because it reaches patients who otherwise tend to fall through the cracks, and it is provided free of charge to the patient. It is targeted to help improve compliance with care plans and lower ER utilization. Paramedics are an excellent resource and partner for such a program because they are highly trained health care professionals who have available down time between emergency calls. The program can be built into a paramedic's regular day without disrupting ability to respond to emergency calls, and makes good use of the paramedic's skills and resources. The special training required in Tennessee for paramedics to become community paramedicine-certified is an asset to the EMS agency as well as the community at large.

Mountain States and Washington County EMS have agreed to fund a pilot program of 10 patients to determine viability of the program and gather outcomes data. The pilot is currently pending legal approval. It is estimated that as many as 500 patients in Washington County alone could benefit from a full-fledged program. The full program would require grant funding; with documentation of positive outcomes, the program would explore reimbursement mechanisms with payers.

C. Primary Care - Behavioral Health Integration

Mountain States Medical Group has contracted with local behavioral health agency, Frontier Health, for the services of a behavioral health care navigator (BHCN) with extensive experience in the field.

The BHCN is a part of the care management team working directly with the AnewCare Medicare Shared Savings Program population attributed to this practice. Currently this individual has 109 patients in her case load. Most of her interaction with patients is during home visits.

Providers, the nurse case manager or any member of the care team may refer patients through the Allscripts IT system to the BHCN. Once a referral is made, the BHCN does a chart review and assesses the behavioral health and social needs of the patient. The navigator provides an assessment of the referred individual's social determinants of health; strengths, needs, abilities and preferences (SNAP); and other relevant assessments to assist in identifying and accessing needed services that will maximize the individual's overall health and well-being. Major duties and responsibilities include:

- Conducting interviews with individuals and/or family members in a therapeutic manner so as to obtain critical and thorough information,
- Providing clinical assessments, service planning, crisis assistance, daily living assistance and linkage, referral and advocacy to/for referred individuals.
- Active involvement with primary care physicians, case managers, and other supportive staff to include ongoing communication and participating in integrated treatment team meetings.
- Providing in-home face to face connection to engage patient in needed services.
- Coordinating with community providers to assist and attend primary and behavioral health care, specialist, community resources, pharmacy, etc. and remaining current in knowledge of community resources and how to access those resources.
- Assisting and attending Primary and Behavioral Health Care appointments with consumers.
- Staying involved in the admission, hospital stay and discharge of individuals on caseload who are admitted to an inpatient primary/psychiatric facility.
- Attending and participating in regularly scheduled staff meetings, in-services and individual program planning staffing as needed.

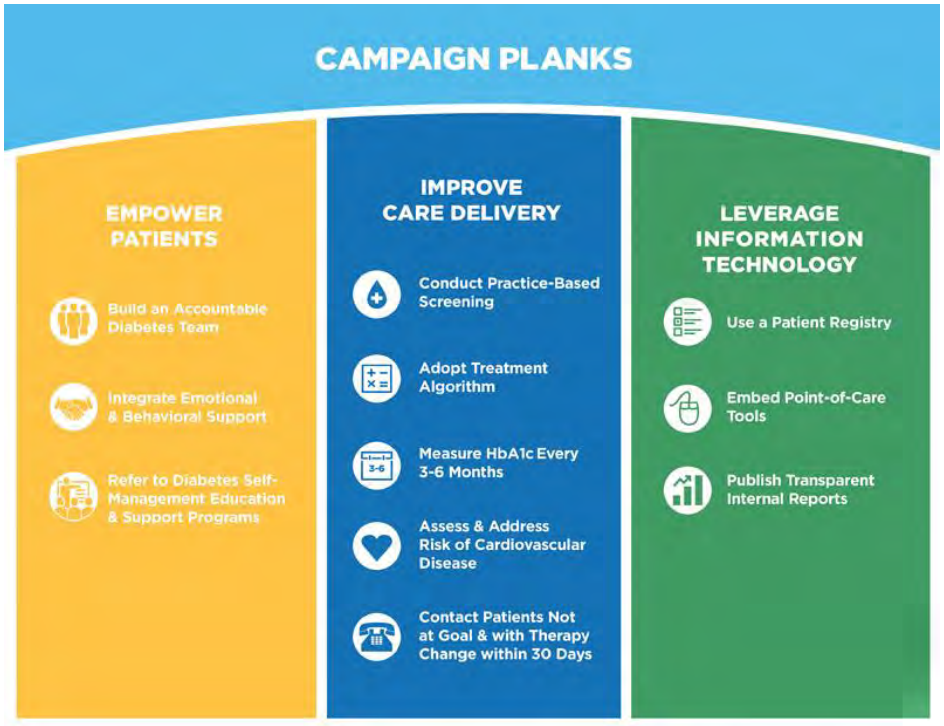
The BHCN addresses limited gap closure when he/she interacts with the patient. Examples include fall risk assessments and substance abuse screenings as may be deemed appropriate. The BHCN documents any interaction information and assessments within the Allscripts medical record. The BHCN records patient interaction in Allscripts through the "Social Determinants of Care Plan." The BHCN is an integral part of the team and interacts with care coordinators, nurses and physicians. The close connection to Frontier Health affords our patient population direct access to other behavioral health professionals. The cornerstone of the BHCN work is the focus on community outreach, and the majority of the contact with patients is through a home visit. This affords the primary care team the ability to learn about patient barriers that would almost never come up during a regular provider office visit.

D. Core Primary Care Team Example

To prepare primary care teams for their work in value-based performance models, Wellmont and Mountain States have worked significantly to re-orient and re-prioritize our approach to primary care and to work with payers to incentivize proactive care management to reduce health costs. Through the American Medical Group Association's Together 2 Goal initiative, Wellmont has adopted a set of primary care campaign planks and training around the model, along with transparent reporting of quality metrics and population risk scores across the medical group's primary care practices. Campaign planks are designed to empower patients to manage their own care, improve care delivery, and leverage information technology through an

integrated approach that includes an accountable diabetes care team, integrated emotional and behavioral support, and diabetes self-management education. In addition, care delivery mechanisms are imported through concerted screenings, a uniform treatment algorithm, regular measurement of HbA1C levels, cardiovascular risk assessment, and communications and coaching for patients who are not achieving goal. A patient registry with point-of-care alerts and embedded tools is used along with transparent and frequent outcomes reported to drive performance.

In this environment, the patient-centered focus is enhanced and team-based care is embedded across all practices with commitment for adherence. The roles of the team include defined responsibilities and goals and the patient and family are considered part of the care team. The stage is set for cross-practice collaboration, especially with specialty practices that support co-related conditions such as cardiology and endocrinology in this example. And, everyone in the practice environment, including the patient, is involved in process improvement and evaluation. This is just one example of the many efforts currently employed by both Wellmont and Mountain States to coordinate and manage care through care teams. As the previous examples set forth, the next manifestation of this coordination under population health is to extend the reach of coordination into community environments or across organizations to gain behavioral health support, social needs support, and deliver care and screening elements in community settings.



E. Pritikin Intensive Cardiac Rehabilitation

Wellmont's Pritikin program is an example of the development of care teams in clinical settings extending engagement into personal and family dynamics to impact lifestyle and behavior change. The program has been proven to reduce the progression of heart disease in patients

with diagnosed disease through a concerted program of education, exercise, diet, sleep, and stress management. Cardiologists and their office staffs reinforce the protocols in the total care regimen. The program also has application for other metabolic conditions where behavior modification is key to the prevention or progression of disease.

Health coordinators join with cardiac rehabilitation specialists and providers in a holistic approach that involves patients and family members both inside and outside of the clinical setting to empower behavior change and a supportive environment for continued success. The traditional exercise elements of cardiac rehab are bolstered by cooking classes, food shopping experiences, de-stressing activities such as yoga, meditation, and flexibility training and healthy sleeping habits. Social and relational reinforcement is also recognized as an important factor to long-term success and participants join with groups of individuals facing similar health challenges for encouragement and shared successes.

II. Challenges and Strategies for Care Team Models

We recognize that challenges will exist in the development of care team models and we have identified the following strategies to address these challenges.

- Challenge: Lack of trained personnel for "new" care team roles.
    - Strategy: Well-trained care coordinators, community health workers, and navigators are not easily available in the market. Education and training programs for these positions do not exist in the local market, and most training must be completed on the job. For example, the Department of Health in Wise County had to develop its own program for community health workers, and it is this program that we partnered with to train the community health workers associated with CareScope360. Oncology navigators at both systems are generally RNs; however, they have also been trained on the job and through out-of-market continuing education. Ballad will work with local two- and four-year colleges to develop curriculum to educate and train individuals to work in these fields.

- Challenge: Greater collaboration and trust.[7]
    - Strategy: According to IHI Director Cindy Hupke, "Team-based care requires greater collaboration than some providers might initially be comfortable with. Across the country, the biggest struggles we see and hear about are when physicians don't trust that another care team member can do a job as well as they do. …they are often unwilling to let go of some of their responsibilities to others who can perform the tasks within their level of licensure and training. Organizations need to mitigate this issue through small-scale testing, training, observation, and collecting data on processes and outcomes to demonstrate reliability and accuracy of the processes."

- Challenge: Differing business models between health care and social support services

[7] Cindy Hupke, INST. FOR HEALTHCARE IMPROVEMENT, *Team-Based Care: Moving from Ideas to Action* (Jan. 2016), *available at* http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?list=7d1126ec-8f63-4a3b-9926-c44ea3036813&id=192.

- Strategy: As health care systems begin to reach out to social support services, either public or private, they may find that different rules, regulations, and motivations may conflict. For example, through a community health worker's home visit, a primary care team may identify that an elderly diabetic individual does not have access to sufficient food appropriate for his/her condition. A natural referral to a support agency providing home meals would be an appropriate solution. If, however, referral protocols are not worked out in advance, that individual could end up on a waiting list for services or could be denied for a variety of eligibility reasons. Ballad will build out its community partner relationships *proactively* and *formally* so both organizations may smooth referrals and other interactions as a matter of policy and procedure, not by chance.

III. How the Merger will Benefit the Deployment of New Care Models

Under the fee-for-service model, many payers still do not explicitly reimburse for services that (i) are not delivered by a physician, (ii) occur outside the clinic, (ii) occur through telemedicine, (iv) are considered "not medical" (such as temporary housing), or (v) occur in a group setting - services that are all hallmarks of the concept of the ECCM. This has hindered the expansion of these models nationally, and locally. As noted in the examples above, a number of the two systems' current efforts are still on a relatively small scale.

As Wellmont and Mountain States have noted, there are limitations placed on their ability to accept greater medical cost risk given the current split of patients and physicians in a community with low population density.[8] With at-risk contracting, payers are more willing to pay a per-member, per-month management fee for care coordination or gap closure important to the ECCM. As a combined health system, Ballad Health will be able to take on more risk, especially through clinically integrated partnerships. It will be able to provide services that are not explicitly reimbursed through direct payments that are designed to drive down the total cost of care and improve quality, resulting in shared savings payments. As outlined in the commitments, Ballad Health will actively seek out these risk-based contracts.[9]

During the transition from fee-for-service to pay for value/risk, Ballad Health will apply funding from the synergies in order to build out the new care teams and other ECCM capacity to specifically address those populations that have no source of reimbursement. As noted in the public health commitments, Ballad Health will implement the Expanded Chronic Care Model approach to high-need high-utilizing uninsured individuals based on the learnings in the CareScope360 pilot discussed above. This would not be possible but for the synergies generated by the merger.

Without the merger it would be extremely difficult, if not impossible, to form fully effective clinically integrated partnerships would can help promote the ECCM. While the Qualuable ACO and the Anewcare ACO, for instance, are both operating in the region, two limits remain. First, Wellmont physicians are not participating because of the initial difficulties experienced in their ACO start-up. But more importantly, there is significant patient leakage that impacts both ACOs because the services in

[8] *See* Response #1 discussing the experience Wellmont and Mountain States have with value-based and risk-based payment arrangements and their strategy to move from traditional fee-for-service to more value-based and risk-based models.
[9] *See* Application, pages 80-81.

the area are not integrated. More than 50% of all spending in Mountain States' AnewCare ACO happens outside Mountain States. A significant portion of these services are delivered by Wellmont or Wellmont-aligned physicians, so it is very difficult to co-manage these patients. By aligning the two systems, this challenge will be greatly reduced to the benefit of both ACOs and any future clinically integrated networks.

Finally the merger will allow for more sophisticated partnerships with community agencies such as Frontier, EMS, Area Councils on Aging, etc. As noted in the Challenges Section above, these organizations all have business models that differ from the core business models of Wellmont and Mountain States. By establishing a single integrated system, Ballad Health will be able to establish common policies, procedures and contractual agreements needed to create a unified system of community partners/affiliated staff in support of these new care models.

Ballad Health
9. Define the IT Strategy

Executive Summary: The transformation to an integrated delivery system will require a significant investment in information technology ("IT") systems. In this section, we describe how Ballad Health will 1) determine the IT components necessary for the transformation and identify where gaps exist; 2) develop the IT governance structure to connect the business strategy with the supporting IT infrastructure; and 3) create a roadmap for implementation of technology to enable the new operational and care delivery processes of Ballad Health.

Encompassed in any population health management strategy is the requirement for supporting information technology and analytics.[1] The investment in electronic health records is a foundational element, but it is the investment in the accompanying IT and analytic systems that will position Ballad Health to successfully pursue population health and risk-based contracts. There will be three aspects to building the IT roadmap for the new organization: 1) determining the IT components necessary and where gaps exist; 2) developing the IT governance to connect the business strategy with the supporting IT infrastructure; and 3) creating a roadmap for implementation of technology to enable the new operational and care delivery processes of Ballad Health.

I. Components of the IT System

Organizations embracing the transformation from traditional fee-for-service to value-based population health require significant investments in IT capabilities. Today, there is no single IT solution that can offer the many components necessary for the transformation, so various systems must be established and connected to achieve the business goals.

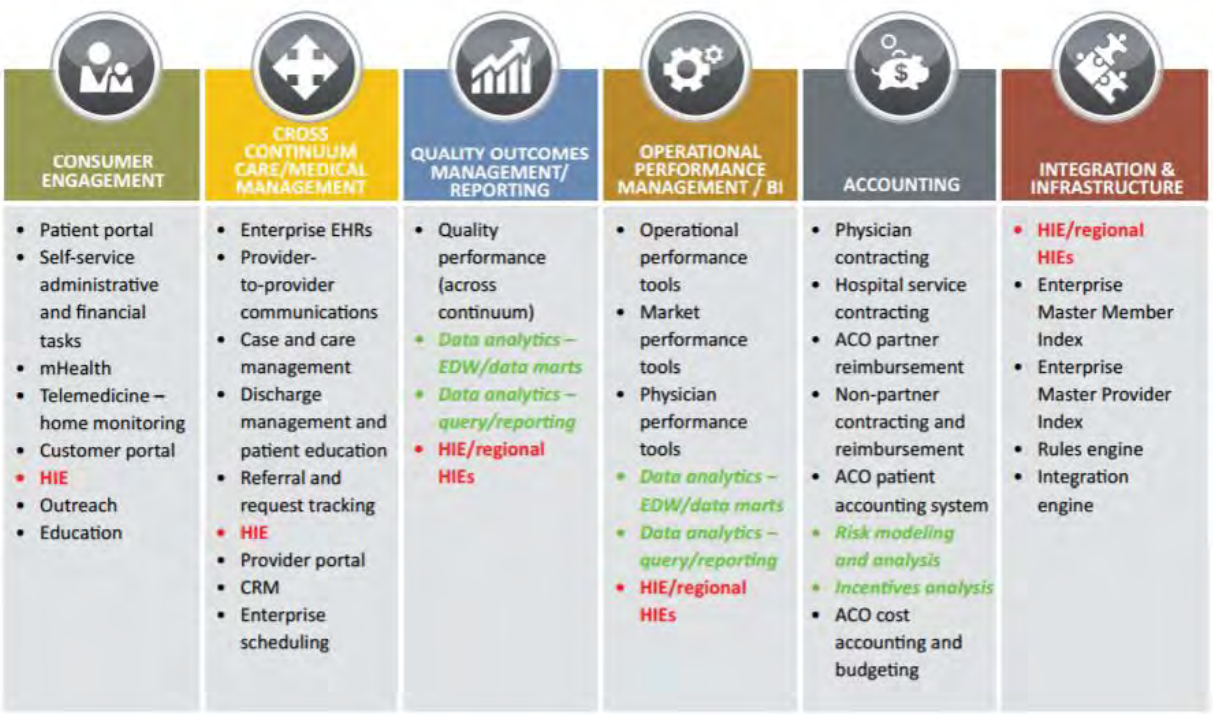
A. IT Assessment

As a first step in identifying what IT system components are needed and what Wellmont and Mountain States are bringing to the merger, the IT Functional Team has begun assessing the IT assets of each the merging entities, including applications, infrastructure, and IT contract portfolios to determine gaps. From this assessment, they will form recommendations and identify the required IT "stack" necessary to deliver a total solution. In this assessment, the IT Functional Team will consider the organization's population health strategy as well as the anticipated value-based contracting strategy. They will consider such factors as:

- Existing IT infrastructure and data sources
- Services provided by public health and social service agencies
- Potential for nontraditional health care data sources (e.g., public health, social services agencies, and consumer purchasing patterns)
- Existing care process strengths and opportunities based on available cost and quality data
- Projected outcome of revenue shift from fee-for-service to value-based contracts

[1] Jacquelyn Hunt et. al, *Guide for Developing an Information Technology Investment Road Map for Population Health Management*, 18(3) POPULATION HEALTH MGMT. 159-71 (June 2015), *available at* http://online.liebertpub.com/doi/full/10.1089/pop.2014.0092.

As demonstrated in the graphic below, IT systems cut across core competencies making IT selection decisions very challenging. The electronic health records ("EHR") and Health Information Exchange ("HIE") capabilities will be needed to support almost all of the foundational areas. Analytic capabilities will be needed for various areas as well, including management, quality outcomes management, and accounting.



Source: *Building a Technology Roadmap that Supports YOUR Organization's Value-Based Care Model*

The IT assessment will be critical to creating an IT road map for population health that inspires confidence across the numerous internal departments that will rely on the IT system. It will be critical to engage the IT, informatics, and business intelligence staff as key partners in the expanded population health planning efforts. It will also be important to engage employed and independent providers in the discussions so they are aware how the IT strategy may affect their practice and/or business.

B. The Infrastructure of the IT System

Once the IT Assessment is completed, the IT Functional Team will determine what core components need to be acquired and what legacy systems may be utilized. The Parties have identified the following components as necessary elements of the IT infrastructure, but others will likely be added once the IT Assessment is complete.

1. Common Clinical IT Platform

The Common Clinical IT Platform will serve as the backbone of the Ballad Health IT System.[2] This common 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 recommended by the Clinical Council. In its Application, Ballad Health has committed to the investment of approximately $150 million over ten years to ensure a Common Clinical IT Platform is implemented and interoperability is available among the New Health System's hospitals, physicians, and related services. The cost of implementation of a Common Clinical IT Platform is built into the capital model for Ballad Health. Standardized order sets, collection of data and standardization of data sharing with physicians are all benefits that would be immediately achieved with the Common Clinical IT Platform once fully implemented. The unified platform will replace the four separate platforms that Wellmont and Mountain States currently operate. The common platform and standardization of process improvements will provide better and almost complete clinical transparency for our patients, their families, and clinicians. It is anticipated that the IT Functional Team will develop a Request for Proposals for the new Common Clinical IT Platform prior to closing. The goal of this group is to be positioned to select an appropriate platform in the first year after closing and begin functional preparation for implementation with particular emphasis placed on organizational responsibility alignment, staffing needs assessment, and timeline development.

2. Region-Wide Health Information Exchange

An HIE 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, Ballad Health has committed to participating in an HIE open to community providers and will ensure its Common Clinical IT Platform interfaces appropriately with the exchanges designed to share health information such that data may be shared with physicians.

A region-wide HIE that includes Ballad Health, independent providers, medical groups and facilities in an effective collaborative model will encourage and support patient and provider connectivity to the integrated information system. In conjunction with the Common Clinical IT Platform, the HIE can be utilized for the management of shared patients between physicians, hospitals, and outpatient settings especially for the avoidance of unnecessary duplication of testing and care coordination to close care gaps. Among other benefits, the seamless sharing of this information will reduce unnecessary cost, mitigate risk to patients and enable improved productivity among providers. After the transaction, the New Health System will commit financial resources to the utilization of an effective HIE. These incremental resources will contribute to the sustainability of an effective HIE model.

[2] Jacquelyn Hunt et. al, *Guide for Developing an Information Technology Investment Road Map for Population Health Management*, 18(3) POPULATION HEALTH MGMT. 159, 160, (June 2015) ("It is clear, however, that successful EHR adoption serves as a foundation to enable [population health management]. The value of health IT investments will be maximized further when coupled with care redesign and incentive changes promoted by value-based payment models."), *available at* http://online.liebertpub.com/doi/full/10.1089/pop.2014.0092.

3. Analytic Systems

Investment in the Common Clinical IT Platform and participation in the region-wide health information exchange will not be enough to support the analytic requirements needed for population health management and risk-based contracting. To allow Ballad Health to successfully pursue these initiatives, the organization will need to invest in sophisticated business analytic systems that facilitate predictive modeling, financial modeling, and cost tracking.

Predictive analytics will be an important component of the IT strategy. Models that predict negative health outcomes before they happen or identify areas for improvement help focus the attention of clinicians, care managers, and administrative staff to do the most good with the fewest resources. By analyzing the enormous amount of data that users collect in the course of their normal workflows, Ballad Health can start to identify historical trends and develop models to predict future events.

Financial modeling will be critical to the financial success of the organization. Risk-based contract models require a new type of financial analysis. If the organization is wrong on modeling medical expenses, significant losses can be experienced. On the other hand, with accurate modeling, the ability to manage care, and various risk-mitigation strategies, there can be appropriate returns.[3] While both Wellmont and Mountain States have experience with risk-based and value-based contracting, the shift towards population health management will require new and refined financial information systems.

Population Health Management will also require sophisticated cost data analytics to better understand the population as a whole and to help identify where the greatest opportunities exist to improve outcomes and lower costs in the setting of limited time and resources. For example, Ballad Health will need to track the unit and case cost for all services for which it will be at risk under a value-based contract to ensure that costs are managed while quality and outcome targets are pursued. The availability and accuracy of this information will be critical to Ballad Health's success. Ballad Health will also need to coordinate with outpatient providers for capturing and accessing data on outpatient costs.

II. IT Governance Structure

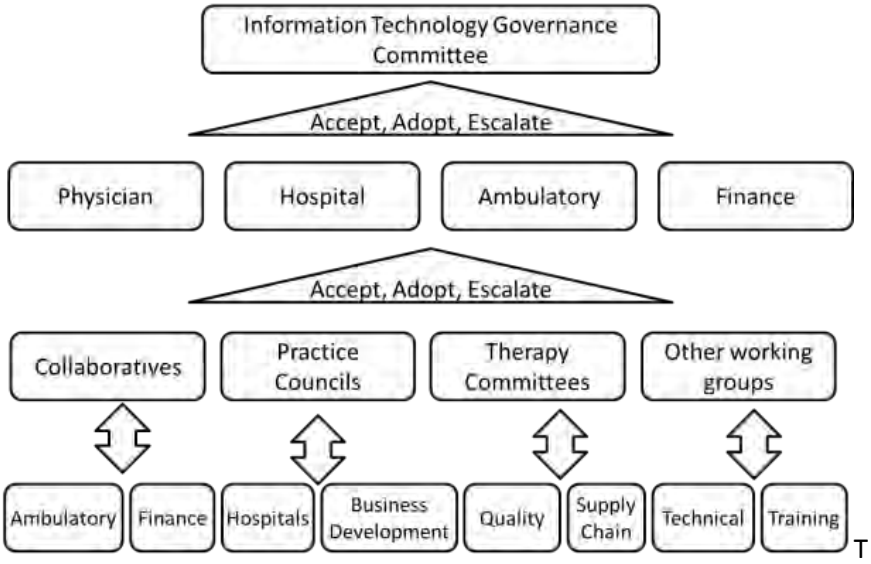
IT governance will be the critical link between business strategy and IT systems for value creation. The overarching Ballad Health population health strategy will drive the transformation, and the IT systems support the clinical and business functions of the organization. To achieve this strategy/support relationship, Ballad Health will design, approve, and socialize an IT governance process that aligns the investments with the population health business strategy.

As a first step, Ballad Health will deploy a fully cross functional Information Technology Governance Committee ("ITGC"). The ITGC will meet monthly (as needed) to receive, consider and validate prospective technology needs, possible solutions, infrastructure compatibility and resource capacity. The ITGC will be co-chaired by both physician and management leadership. The committee will consist of senior executive leadership representation from all geographical markets, senior corporate leadership

[3] *See* Response #1, Section IV.B for more detailed discussion.

representation from operations, finance, information technology and legal, designated facility Chief Nursing Officer and Chief Medical Officer, and subject matter experts as needed.

The ITGC will be charged with determining if projects and associated expenditures meet with the strategic direction of Ballad Health and whether the Information Technology department has sufficient capacity to meet the desired project on-time and on budget. The following diagram represents the anticipated IT governance workflow.



III. Roadmap for Implementation

If the COPA is approved, the Parties expect to build upon the work the IT Functional Team has already done to determine the roadmap for implementation. Ballad Health will fully assess the IT assets of each of the merging entities including applications, infrastructure, and IT contract portfolios to best determine gaps, form recommendations and secure the required IT stack to deliver a holistic solution. The IT assessment is expected to take at least six months after Ballad Health 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 has been submitted to the state for reference.[4] Additionally, estimates for how and when the $150 million will be spent on the Common Clinical IT Platform has also been provided to state.[5]

The following graphic outlines the approach Ballad Health intends to take as it pursues an IT Strategy that will successfully support the transition to a community health improvement organization.

[4] *See* Responses to Questions Submitted April 22, 2016, Exhibit 17.
[5] *See* Responses to Questions Submitted April 22, 2016, Exhibit 18

Population Identification

Requirements	Systems
• Data acquisitions and aggregation • Analytics-based population definition and contracting • Predictive modeling • Algorithmic population identification • Patient-provider attribution	• Data aggregation platform: EMR clinical data repository (CDR): clinical data warehouse (CDW). • Claims data source • Statistical modeling tools • Algorithms and analytics for inclusion/exclusion criteria by population • Process, algorithms for attribution

Population Tracking

Requirements	Systems
• Populations: High risk/high utilization; Chronic disease group; Preventive care • Map against care guidelines • Map against care over time	• Disease / population registries

Care Delivery

Requirements	Systems
• Clinical data view, e-prescribing, clinical documentation • Patient-centered view of interventions due • Decision support for interventions	• EMR or physician portal • Registry: patient-centered view • 3rd Party Clinical Systems

Cross-Continuum Care Management

Requirements	Systems
• Care manager: patient data access, clinical documentation, communication tools • Care plan mapped against patient data • Remote data acquisition: vital signs, lab values • Real-time video interaction at remote locations	• Patient portal • Text-based communication system • Provider mobile devices • Call center • Case management tool

Administration Performance Monitoring, and Reporting

Requirements	Systems
• Contract negotiation and management • Revenue distribution • E-measure calculation and reporting • Performance data at clinical, practice, organization-wide levels • Value based metrics	• Data aggregation and analysis platform • Dashboards, self service display tools • Linked contract management and financial systems • Revenue cycle systems • Financial decision support/cost accounting

Ballad Health
10. Evidence and Rationale for Investment in Residential Addiction Treatment Capacity

Executive Summary: The state of Tennessee is disproportionately struggling with the prescription drug abuse epidemic. Tennessee has experienced a 250% increase in opioid-related overdose deaths from 2001 to 2010 and the counties in Northeast Tennessee have some of the worst substance abuse measures in the state. As the need for substance abuse treatment services increases, the types of services available at each level of the care continuum must be expanded. Residential treatment facilities occupy an important role for treatment of complex and severe substance abuse cases. Due to the rampant substance abuse issues in the region and the prevalence of behavioral health issues, it is necessary to invest resources in all levels of the substance abuse care continuum, but particularly in resources like residential treatment facilities that are capable of addressing complex and severe substance abuse issues.

The extent of the addiction crisis is well documented in the applicant's service area.[1] In addition, during the Community Health Roundtable meetings, where ETSU brought together 225 people across ten separate events between August-October, 2015, substance abuse was identified as the second largest topic of concern in the community.[2] Nationally, the CDC recently reported that in 2015 opioid deaths surpassed 30,000 for the first time in history and that heroin overdoses now kill more people than fire-arm related homicides.[3] As a result, substance abuse prevention and treatment services were identified as top priorities in the Applicants' suggested investments in public health initiatives[4] and improved specialty services access.[5]

While prevention of substance abuse is preferred, and the applicants include investments for prevention in their proposed public health initiative plan, according to the NIH National Institute on Drug Abuse ("NIDA") "the 'treatment gap' is massive—that is, among those who need treatment for a substance use disorder, few receive it. In 2011, 21.6 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem, but only 2.3 million received treatment at a specialty substance abuse facility."[6]

NIDA identifies several steps in successful drug treatment: detoxification, behavioral counseling, medication, evaluation and treatment for co-occurring mental health issues, and long-term follow-up to prevent relapse.[7] The American Society of Addiction Medicine ("ASAM") identifies five broad levels of

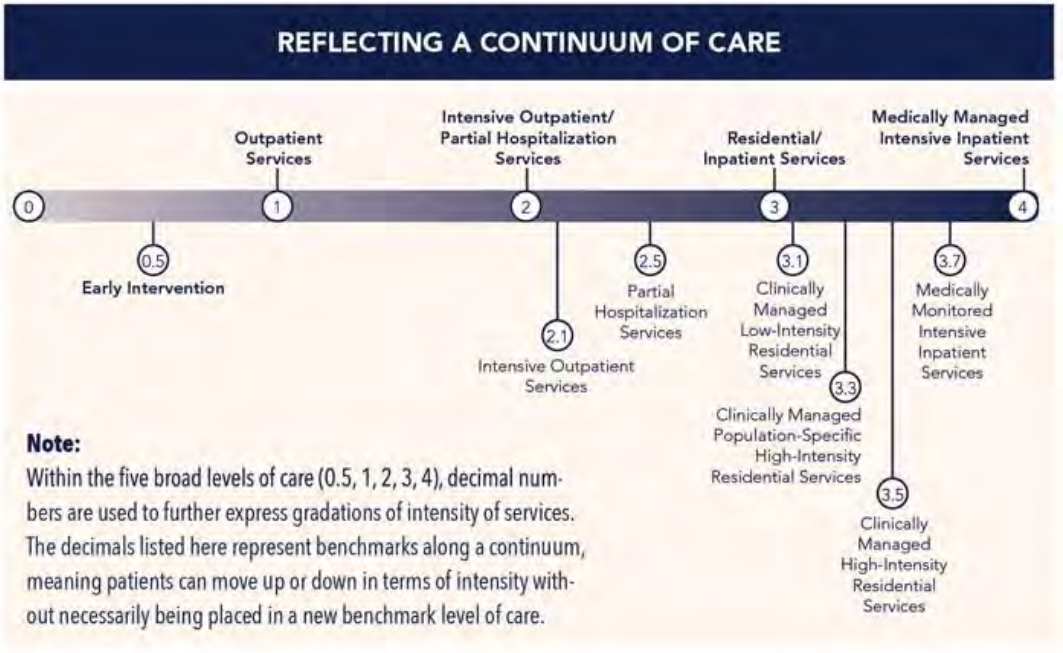
[1] *See* Application for Certificate of Public Advantage, State of Tennessee, at 32.
[2] *See* Attachment E to the Pre-Submission Report (provided as Exhibit 10.1 to the Application).
[3] *See* Christopher Ingraham, *Heroin Deaths Surpass Gun Homicides for the First Time, CDC Data Show*, THE WASHINGTON POST, December 8, 2016, *available at* https://www.washingtonpost.com/news/wonk/wp/2016/12/08/heroin-deaths-surpass-gun-homicides-for-the-first-time-cdc-data-show/?utm_term=.ba15a2ff5215 .
[4] Response to Questions Submitted April 22, 2016, at 20-21.
[5] Application for Certificate of Public Advantage, State of Tennessee, at 7.
[6] NAT. INST. ON DRUG ABUSE, *Principles of Drug Addiction Treatment: A Research-Based Guide* 15-16 (3d ed. 2012), *available at* https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-do-we-get-more-substance-abusing-people.
[7] NAT. INST. ON DRUG ABUSE, *DrugFacts* 2 (July 2016), *available at* https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction.

care (see Figure 1) across a continuum of service intensity, ranging from early intervention for individuals with known risk factors through the medical management of intensive inpatient services. Full-time facility based residential and inpatient services comprise levels three and four of this continuum. Residential services range from medically managed detoxification to lower intensity recovery housing in post-residential after care.

Detoxification is a necessary first step in addiction treatment, not only because the process of withdrawal for some addictions is often physiologically difficult, painful and dangerous, but also because the nature of addiction corrupts the rational thought processes of the addicted individual. Residential settings are often required to provide the medical management and structure necessary to complete the detoxification process, especially in the case of individuals with co-occurring mental illness, medical complications, or criminal justice and social services involvement often associated with individuals with substance abuse disorder.[8]

A sufficient number of detoxification and residential beds is important because research has shown that successful treatment depends on quick access to treatment and length of time in treatment.[9,10] When individuals are placed on waiting lists, 25-50 percent never enter treatment. [11] Lengths of stay in residential treatment greater than 90 days show significantly better results in one-year post follow up than shorter lengths of stay.[12]

Figure 1: ASAM Continuum of Service Intensity



[8] *Id.*
[9] *Id.*
[10] NAT. INST. ON DRUG ABUSE: RESEARCH REPORT SERIES, *Therapeutic Community* (2012), *available at* https://archives.drugabuse.gov/pdf/RRTherapeutic.pdf.
[11] JongSerl Chun, et. al, *Drug Treatment Outcomes for Persons on Waiting Lists*, 34:5 AM. J. DRUG ALCOHOL ABUSE 526 (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2766557/.
[12] *Therepeutic Community*, *supra* n10.

The State of Tennesee Department of Mental Health and Substance Abuse Services has found that overall the state suffers from a lack of medically monitored detoxification services and services for pregnant women with addictions.[13] In the Departments 2017-2019 Year One Plan, the Division of Substance Abuse Services sets specific objectives for year one to "make available programs that serve individuals who have been convicted of a non-violent crime and have a substance use or co-occurring disorder, provide an array of recovery support services for adult and adolescent consumers to supplement their treatment and to increase their chances of long term sobriety, and establish new recovery homes statewide."[14] The Tennessee Department of Mental Health Planning and Policy Council 2016 Needs Assessment Summary finds specifically that in Regions I and II which encompass the Applicants' Geographic Service Area, that there is a need for recovery focused housing, and residential bed and detoxification services for individuals without insurance and the underinsured.[15]

In addition, local mental health experts in Northeast Tennessee and Southwest Virginia serving on the Mental Health and Addictions Steering Committee organized by the Applicants last year were:

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

Dr. Terri Kidd, President and CEO for Frontier Health, reports that there is currently a 125 person waiting list for medically managed detoxification services at their Magnolia Ridge facility, which equates to a four to six week wait time. As stated earlier, 25-50 percent of indiviudals seeking treatment who are placed on waiting lists later decide not to seek or accept treatment. According to Dr. Kidd "as soon as you put them on a waiting list, you've lost them."

Ballad Health's proposed residential treatment services will include additional medical detoxification services, and will build longer-term residential services based on the "theraputic community" model. Theraputic communities are designed around two fundamental concepts: the community as change agent and the efficacy of self-help.[16] The focus is recovery which "is seen as a gradual, ongoing process of cognitive change through clinical interventions" where "participants progress through the stages of recovery, they assume greater personal and social responsibilities in the community."[17] Interventions include clinical groups, community meetings, and vocational, educational, community, and clinical

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[13] Mario Lehenbauer-Baum, DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES, STATE OF TENNESSEE, *Needs Assessment Data Report 2015*, January 2016, *available at* https://tn.gov/assets/entities/behavioral-health/p-r-f/attachments/FY2015_Needs_Assessment_Data_Report.pdf.

[14] DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES, STATE OF TENNESSEE, *2017-2019 Three-Year Plan*, Slide 12, *available at* https://tn.gov/assets/entities/behavioral-health/p-r-f/attachments/2017-2019_Three-Year_Plan_FINAL.pdf.

[15] OFFICE OF PLANNING, DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES, STATE OF TENNESSEE, *2016 Needs Assessment Summary*, at 1-2, April 4, 2016, *available at* https://tn.gov/assets/entities/behavioral-health/p-r-f/attachments/2016_TDMHSASPPC_Needs_Assessment_Summary.pdf.

[16] *Therepeutic Community*, *supra* n10 at 4.

[17] NAT. INST. ON DRUG ABUSE: RESEARCH REPORT SERIES, *Therapeutic Communities* 1-3 (July 2015), *available at* https://www.drugabuse.gov/publications/research-reports/therapeutic-communities/what-therapeutic-communitys-approach.

activities.[18] In addition to serving the general populations, programs for specific groups will be developed, intially beginning with youth and adolescents and pregnant women with substance abuse disorders.

As noted in the Application, investments will be made in community based support services to support graduates of residential programs. Aftercare services typically include individual and family counseling, self-help groups and supported employment and education services.

[18] *Therepeutic Community*, *supra* n10 at 5.

Ballad Health
11. Plan for Community Partnership and Collaboration

Executive Summary: In this response, we outline the plans for community partnership and collaboration which complement Ballad Health's transformation from two individual and traditional health care delivery systems to a fully integrated and aligned health care delivery system responsible for providing value-driven community health improvement. A key component of that transformation is new kinds of partnership and collaboration efforts with providers of care and community stakeholders through the development of the Accountable Care Community together with a Community Health Improvement Plan and regionally coordinated and scaled efforts around common objectives. We envision that state or regional Department of Health leaders will serve in key roles for the Accountable Care Community.

Building the Key Partnerships and Collaborations

This response focuses on Ballad Health's plans for community partnership and collaboration. Aligning existing organizations and resources for community health improvement provides an important underpinning for community health improvement within the Geographic Service Area.

As mentioned in the Overview, the establishment of the Accountable Care Community will allow Ballad Health to work with its partners to meaningfully and measurably impact the health of the whole population. This model extends the benefits of the critical transformation within the healthcare delivery system into specific partnerships and affiliations in the immediate community to address the agreed upon population health needs.

A. The Community Health Improvement Framework

Our over-arching model for community collaboration and partnership is defined by the **Community Health Improvement Framework** outlined below and the interface of its components—the three environments of prevention activity (clinical settings, personal settings, and community settings), the three types of prevention (primary, secondary, and tertiary), and the engagement of essential cross-sector partners through an Accountable Care Community with utilization of the right resources to improve health proactively.

It is important to note that we include the clinical setting in the Community Health Partnership Framework even though we make a clear distinction between population medicine and community health improvement. These strategies can and should be connected, and the engagement of physicians with their patients is absolutely essential to improving the overall health of the community. Physicians, nurses, and other clinical professionals have a significant ability to influence their patients to make sound decisions which will affect their health outcomes.

Prevention Environment Strategies

1. Clinical Settings - Increase the use of clinical preventative services with provider partners (optimize clinical engagements)

2. Personal Settings - Provide services that extend outside the clinical setting with community partners and patients (mobile and community based screenings, immunizations, educational programs, and home-based programs)
3. Community Settings - Implement interventions that reach whole populations with community partners and patients (policy, environment, behavior)

In order to effectively impact the three areas of the Triple Aim comprehensively across a diverse population, it is essential to create strategies that reach into each of these environments. Auerbach describes these environments as The Three Buckets of Prevention in the *Journal of Public Health Management Practice* (2016).[1]

It is also essential to impact all three types of prevention—with a significant focus on primary prevention strategies:

Prevention Type Strategies

1. Employ primary prevention strategies to keep disease from developing. Examples:
    - Population Medicine Strategy: In order to fully advance primary prevention practice, clinical providers must be engaged and informed of the strategies necessary to address prevention issues within the clinical context. Clinicians often do not grasp how they can have an impact on the factors that lead to many illnesses and injuries in the first place.[2] Part of the plan will include trainings on community prevention for clinical providers and other health care organizations to build a team of individuals that are deeply versed on community prevention principles and strategies.

    - Community Health Improvement Strategy: In order to reach people effectively, especially those in rural or underserved populations, we will use mobile health resources and partnerships with community organizations to enact elements of the Community Health Improvement Plan, including screenings for risk factors, immunizations, preventative dental services, and risk assessments to connect individuals to primary care and social supports. We will also enact community based health education and interventions to increase health literacy and engage people in behavior change such as healthy eating and moving more.

2. Employ secondary prevention strategies to slow or stop the progression of disease. Examples:
    - Population Medicine Strategy: Through the implementation of the Common Clinical IT Platform, protocols and alerts will be embedded in the IT system to identify individuals with health risks who need intervention or lifestyle changes to prevent the progression of heart disease, behavior related cancers, and diabetes.

    - Community Health Improvement Strategy: Mobile and community based screenings will allow the identification of high risk individuals who need educational resources,

[1] John Auerbach, *The 3 Buckets of Prevention*, 22:3 J. PUB. HEALTH MGMT. AND PRAC. 215 (2016).
[2] *See* PREVENTION INST., *Opportunities for Advancing Community Prevention in the State Innovation Models Initiative* (Feb. 2013), *available at* https://www.preventioninstitute.org/sites/default/files/editor_uploads/images/stories/Documents/CMMI_SIM_Initiative_Memo_February_2013.pdf.

connection to primary care, or specific tools to enact lifestyle changes to avoid the progression of high-blood pressure to heart disease or high AIC levels to type II diabetes, for example.

3. Employ tertiary prevention strategies through population medicine strategies and community health improvement strategies to manage disease effectively and mitigate negative effects. Examples:
    - Diabetes Management: Effective clinical management of diabetes will allow the avoidance of complication and hospitalization
    - Heart Failure Management: Effective heart failure management strategies, shared between cardiologists and primary care physicians will allow the avoidance of re-hospitalization and disease progression
    - Intensive Cardiac Rehab: Intensive cardiac rehabilitation opportunities such as the Pritikin program will allow individuals to slow or reverse the progression of heart disease through lifestyle change and to also influence the behavior of family and friends in support networks
    - Community Health Improvement Strategy: We will work to connect community partners that address social factors with discharged or chronically ill patients in way that positively impacts the health. Programs like Meals on Wheels and organizations that offer assistance with housing and utilities can offer resources in the community setting that will have a significant impact on the health status of disease patients.

Finally, the right resources will need to be developed to inform strategy, drive actions, and ensure effective evaluation within the framework. By mobilizing resources around a specific goal, the opportunity to coordinate services across the community and limit duplication of parallel or competing efforts is improved.[3] To that end, the Accountable Care Community will conduct an inventory of resources to identify gaps and strengthen connections between prevention resources with a specific focus on the following:

<u>Prevention Resources</u>

1. Human Resources. Examples:
    - Ballad Health staff members and physicians
    - Independent physicians
    - Community partners
    - Community service boards
    - School systems
    - Faith-based organizations
    - Resource agencies such as housing departments, courts, and non-profits (e.g. Meals on Wheels)

2. Financial Resources. Examples:

[3] *See* FAEGREBD CONSULTING, AUSTEN BIOINNOVATION INST., *Healthier By Design: Creating Accountable Care Communities* (Feb. 2012), *available at* http://www.faegrebdc.com/webfiles/accwhitepaper12012v5final.pdf.

- Eliminating the duplication in medical care delivery to free up resources that can be redeployed to upstream activities that address underlying behavioral, environmental and social determinants of health
- Pursuing value-based and risk-based payment arrangements that reward population health management/medicine
- Using financial capital to increase the community's social capital through the development of effective partnerships
- Utilizing the funding set forth in the COPA commitments to empower activities and plans
- Identifying common funding and activities within the Accountable Care Community membership that can be better leveraged if coordinated
- Identifying public and private grant opportunities to support and advance the community goals

3. Health IT Resources. Examples:
    - Implementing a Common Clinical IT Platform to coordinate health care across the region
    - Utilization of a Health Information Exchange to share community health data with health care providers across the region
    - Using electronic health record and data analysis capabilities to promote linkages with other sectors' data and create a dashboard to track progress on community health indicators

4. Education/Training/Communication Resources. Examples:
    - Partnering with local organizations, including faith-based and educational institutions, to educate individuals on disease prevention and health screening opportunities
    - Educating and training local healthcare providers in prevention strategies in the clinical context
    - Supporting important local and state public health initiatives, such as opioid abuse prevention efforts and water fluoridation programs, through communications campaigns and advocacy efforts
    - Establishing communications platforms to coordinate resources and initiatives across the multi-sector partnerships, increase buy-in amongst the partners, recruit new members, and attract grant investment to support the Accountable Care Community, as well as share best practices across the multi-sector partners

5. Best Practice Intervention Resources. Examples:
    - Utilizing inter-professional teams including, medicine, pharmacy, public health, nursing, social work, mental health, and nutrition, to align care management and improve patient access and care coordination
    - Coordinating community-wide immunization programs and educational efforts
    - Adopting evidence-based screening assessments by clinical partners
    - Implementing screening programs by healthcare and social service providers to improve referral policies and services for mental health and substance abuse patients
    - Establishing health coaching programs
    - Utilizing transition programs and acute care networks to reduce hospital readmissions
    - Exploring programs such as Centering Pregnancy and Nurse Family Partnership

B. Recruiting and Organizing the Members

By serving as a central organizer in the Accountable Care Community, Ballad Health can improve efficiency and reduce redundancy in community efforts by strengthening the links between existing programs, capitalizing on current resources, and building novel solutions to all health issues. Through the inclusion of these broad-base community-wide partnerships, the interconnections can be strengthened and duplication of efforts will be reduced. By mobilizing the coalition in coordinated and collaborative efforts, the goal of the ACC to improve the physical, social, intellectual, emotional, and spiritual health of the community will be realized.

Ballad Health will identify essential accountable partners across the region and engage them in the establishment of the Accountable Care Community focused on the Community Health Improvement Plan using the following steps:

1. Surveying Interest and Capabilities

Part of the process of establishing the Accountable Care Community will be the development of a survey or other assessment or response tool which will allow regional organizations to outline their capabilities and interest in participation. This will be followed up with one on one interaction and assessment of interest. Though we have not yet conducted this survey, our interactions with regional organizations and their participation in the Community Work Groups led by ETSU are a strong indication of support and interest. Many relationships exist but will have to be strengthened and become more interdependent to achieve success.

2. Identification and Recruitment of Members

Members of the Accountable Care Community will be recruited based on their multi-sector leadership and their willingness to commit to be an accountable partner in the development of cohesive regional community health improvement efforts. This includes identifying common goals and building each organization's contribution to these goals into organization-specific workplans.

This coalition is a multi-sector partnership with robust participation from the community with a diverse membership including representation from: public health, medicine, health systems, higher education, secondary education, safety-net health services, academic researchers, practicing health care providers, alcohol/drug/mental health services, local chapters of national health organizations, the faith and service community, local issue-focused coalitions and multiple community-based programs.

Fortunately, the leaders of Wellmont and Mountain States have cultivated strong working relationships over the last several decades with numerous community organizations. These relationships will provide the foundation for the Accountable Care Community partnerships. Ballad Health will utilize mutually accountable covenant commitments to establish the responsibilities and expectations for the Accountable Care Community partnerships. Both existing health systems have strong relationships with regional organizations which need to be further developed under the Accountable Care Community model.

C. Defining Common Objectives.

Based on the Community Health Improvement Plan, Ballad Health and its partners will articulate the common vision of community health, identify stewardship priorities, and develop an action and investment agenda around shared goals and measures. This step will be essential to the broad aim of impacting all of the factors leading to improved health outcomes including behavioral and social determinants of health. One of the major premises of this approach is to activate community-based prevention, particularly interventions that look upstream to address the root causes of disease and affect proactive change through prevention activities in environments that are typically outside of the clinical realm and the traditional clinical environments.

D. Creating Accountability.

A leadership council or board will govern the work of the Accountable Care Community and sub-committees may be developed based on sub-regional designations such as cities, counties, or other connected geographies.

The Partners, including Ballad Health, will adopt mutually accountable covenant commitments and focus comprehensive efforts around common objectives. Each partner commits to building their specific contribution to the Accountable Care Community goals into their own organization's goals and objectives. The partners will include the breadth of organizations that are able to help the Accountable Care Community fulfill its charge of implementing comprehensive efforts to improve the health of the entire population in the Geographic Service Area.

Ballad Health will provide financial investments to accountable partners to focus on priority efforts with clear, contractual expectations for how those funds will be used and a clear system for evaluating compliance, evaluation, and success.

Through these efforts, Ballad Health intends to align the components of the Accountable Care Community and aim them effectively to target health improvement in our region in a way that creates clear advantage for payers (individuals, insurance companies, government payers, and employers), providers (physicians, hospitals, ancillary services), and the people and communities we serve—including underserved populations or those experiencing health disparities.

Ballad Health
12. The State of Regional Program Support for Population Health Improvement

Executive Summary: In this response, we outline the state of regional program support for population health improvement including an overview of the current status of efforts by partnership category along with the penetration of those programs regionally and a description of the new Ballad Health strategy related to each category. We seek to build on these key partnerships and collaborations to enact the transformation needed to substantially improve regional health through community health improvement and population medicine strategies. The partnership groups outlined are those essential to the development of a multi-sector Accountable Care Community as well as those needed to impact the personal, clinical, and community settings essential to shaping prevention efforts across the population and the social and behavioral determinants of health. Clinical Partners, Public Sector Partners, and Private Sector Partners and Payers are all needed to inform strategy, drive actions, and ensure effective evaluation within the Community Health Improvement Framework referenced in Response 11. Importantly, many of the partners mentioned here participated actively in the Community Work Group Process led by the ETSU College of Public Health which will serve as the foundation for a Ten Year Community Health Improvement Plan to be driven by the Accountable Care Community. Those organizations feel ownership for this plan and are anxiously awaiting next steps in the process.

To address the social and economic factors that affect health, population health improvement initiatives must reach beyond the traditional boundaries of the health care system.[1] Ballad Health intends to use community-based partnerships that bring a wide range of stakeholders— clinical partners, public sector partners, private sector partners and payers —together to promote healthy behavior, improve access to primary and preventive care, and reduce health disparities. This approach has shown to be an effective means of improving population health.[2]

Ballad Health will not be building these partnerships from scratch. Wellmont and Mountain States have long-standing relationships with stakeholders in each of these categories that have been cultivated over decades of community work. Because of these long-standing relationships, the community is primed for an Accountable Care Community model under the leadership of Ballad Health. Below is a summary of the existing relationships with each of the categories of stakeholders, the regional penetration of that existing partnership, and a description of Ballad Health's plans to build upon that relationship to successfully implement an Accountable Care Community.

[1] According to a widely cited model from the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, population health is determined by several different factors—with access to and the quality of clinical care accounting for just 20 percent.

[2] *See* THE COMMONWEALTH FUND, *Improving Population Health Through Communitywide Partnerships* (Feb./Mar. 2012) ("Community health partnerships that bring clinicians together with civic groups, social service providers, and educational leaders among many others are proving to be an effective means of improving population health.").

I. Clinical Partners

A. Hospitals

Current Status: Mountain States and Wellmont are the two primary health systems operating in the Geographic Service Area. Their tertiary and ambulatory networks work hand in hand with smaller area hospitals, including those operated by the two health systems, as well as a variety of home health, rehab, and other post-acute providers and thousands of independent physicians. As comprehensive health systems, Wellmont and Mountain States include a full spectrum of care options for patients in a traditional fee-for-service, hospital-centric care delivery model. Both health systems have experience managing ventures into population medicine or risk-based models including Accountable Care Organizations. Each system also manages a substantial number of value-based-purchasing, pay-for-performance, or bundled payment models - including those with insurance companies, state Medicaid programs, and CMS. The health systems currently support community health improvement activities in partnership with other organizations, such as Healthy Kingsport, and support the social needs of community members through their own foundations' patient assistance funds. Under their social responsibility requirements both systems also provide significant donations to a number of community organizations that provide education and relief across the region, and employees of the two health systems actively volunteer in the community.

In addition to the hospitals owned by Wellmont and Mountain States, independent hospitals and hospitals associated with other health systems operate in Morristown, Newport, and Greeneville, Tennessee and in Tazewell, Grundy, Wytheville, and Richlands in Virginia.[3]

Regional Penetration: Hospitals are located in nearly every county within the Geographic Service Area, with tertiary hospitals centered in the Tri-Cities and community hospitals located in more rural markets.[4]

New Ballad Health Strategy: Ballad Health will create a cohesive regional approach to population medicine, which allows the current fee-for-service and hospital-centric model to further develop into a community health improvement organization. The new model will proactively seek to prevent disease, in addition to treating it effectively, and will center its existence on the Triple Aim. Ballad Health will expand internal mechanisms needed to assume more risk for the health status of the populations it serves and will work with partners to establish an Accountable Care Community organization capable of high-performing collaboration to enact community health improvement. In addition to sustaining the current investments in community benefit, Ballad Health will invest $450 million over ten years to empower its new focus, both internally and externally, in support of the population health plan and will work with partners to implement and actively supervise that investment.

[3] General acute care hospitals in the Geographic Service Area not operated by Wellmont or Mountain States include: Clinch Valley Medical Center, Wythe County Community Hospital, Carilion Tazewell Community Hospital, Lakeway Regional Hospital, Buchanan General Hospital, Morristown-Hamblen Healthcare System, and Newport Medical Center. *See* Application for Certificate of Public Advantage, State of Tennessee, Exhibit 5.2.

[4] *See* Application for Certificate of Public Advantage, State of Tennessee, Exhibit 5.1.

B. Physician Groups

Current Status: Thousands of physicians operate in the Geographic Service Area, the vast majority of which are independent from the two health systems.[5] Large physician groups in the area include State of Franklin Healthcare Associates, Holston Medical Group, ETSU physicians, Medical Care, and Mountain Region Family Medicine.

Two Accountable Care Organizations ("ACOs") also operate in the area, including Qualuable, a Medicare Shared Savings Program ACO based in Kingsport, Tennessee, which manages approximately 21,000 Medicare Shared Savings Program ("MSSP") lives and includes the large independent physician groups. Through its Integrated Health Solutions Network subsidiary Mountain States operates the Anew Care Collaborative ACO based in Johnson City, Tennessee, which manages approximately 14,000 MSSP lives and 17,000 TennCare lives under contract with Amerigroup. Both ACOs are among the few MSSP programs which have received shared savings during each year of their existence and both received high quality scores in excess of 2015. In 2013, Wellmont established the Wellmont Integrated Network ACO, which allowed the health system to develop important resources for care management for approximately 9,000 lives. Wellmont was unable to achieve a critical mass of lives necessary to financially support the ACO and ultimately discontinued the program in 2014.

While Wellmont Medical Associates and Mountain States Medical Group are owned and operated by the two health systems, both health systems work with all of the physicians on the medical staffs, as well as community-based physicians and post-acute care providers, to care for mutual patients. Both Wellmont and Mountain States manage provider networks. Mountain States' Integrated Health Solutions Network maintains a provider network in Tennessee and Virginia. This network is made available to a variety of insurers, including BlueCross BlueShield of Tennessee. Wellmont similarly participates in Highlands Wellmont Health Network, a physician-hospital organization which provides a network of providers and contracts with insurance companies as well as providing services for self-insured businesses.

Both Wellmont and Mountain States currently participate in the One Partner HIE as contributing providers, meaning they provide data to the HIE which helps all participating physicians manage care more effectively and efficiently. In addition, through its Epic EHR system, Wellmont offers Epic Carelink at no cost to regional physicians who need to access to health system based patient records from their offices or for their own care management efforts.

Most of the larger medical groups in the Geographic Service Area, including Wellmont and Mountain States, have established patient-centered medical homes employing the national standards set forth by the American Medical Group Association and similar organizations to manage the care of patients. These patient-centered medical home initiatives manage chronic disease such as diabetes and contributors to the development of disease such as obesity and tobacco use. The development of these initiatives, together with regional ACO strategies and their associated care management departments, have helped to create a new orientation to

[5] Of the more than 2,000 physicians in the Geographic Services Area, approximately seventy percent (70%) are independent. *See* Application for Certificate of Public Advantage, State of Tennessee, Exhibit 6.1E.

patient care especially in the major medical groups. This new orientation has contributed to area physician groups' ability to succeed in value-based payment models.

Federally Qualified Health Centers, Rural Health Centers, and Charity Clinics also house important physician resources, especially for primary care and dental services. These centers are especially important to bridging care gaps in rural areas and in reaching underserved and uninsured populations in both rural areas and cities. Federally Qualified Health Centers include the Rural Health Consortium operating in Northeast Tennessee and Stone Mountain Health Services and Southwest Virginia Health Systems operating in Southwest Virginia. Charity Clinics include Friends in Need and Healing Hands operating in Kingsport, Tennessee and Bristol, Tennessee respectively, and The Health Wagon and Crossroads Medical Mission operating in Southwest Virginia. A variety of other faith-based or community clinics also contribute to serving the underserved and uninsured populations of the area.

Regional Penetration: Physician practices are concentrated in the more populated areas of the Geographic Service Area but span the area, and the majority of independent physicians operate in proximity to the more populated areas. Specialty physicians are also primarily based in population centers, with a few exceptions. Physician needs in the more rural areas are primarily supported by the two health systems, independent hospitals or Federally Qualified Health Centers, along with notable independent practices such as Medical Care LLC in Tennessee and C-Health in Virginia. Because of difficulty recruiting physicians to rural areas, Mountain States and Wellmont both employ larger percentages of physicians in these rural areas than they do in the more populated areas.

Ballad Health Strategy: Ballad Health seeks to build on the work that has already begun in the regional ACOs to further align clinical efforts through a more cohesive clinical network that includes employed and independent physicians. This strategy will emphasize the mutually supportive contributions to common population health medicine strategies aimed at reducing cost, improving quality, and increasing access to prevention and best practice treatment resources. As described in the Overview Section, physician group leaders will be important leaders for the Accountable Care Community and a cross-section of regional physicians will contribute to the Physician Clinical Council—where clinical protocols and strategies to derive efficiency and improve quality will be vested for Ballad Health. Each of these organizations will be a cornerstone for community health improvement. The sharing of health information will be essential to this network as well, so Ballad Health will not only work to develop the Common Clinical IT Platform but will also meaningful participate in a regionally accessible health information exchange. Ballad Health will seek to empower independent group participation in cooperation with large regional medical groups.

C. Non-Acute Care Providers

Current Status: This clinical category includes rehabilitation centers, nursing homes, home health and hospice, and pharmacies - organizations which touch patients both before and after acute care experiences. Mountain States and Wellmont, as well as our physician networks, work closely with a variety of these non-acute care providers to manage the care of patients, but much of that work is disconnected and uncoordinated today. Some exceptions exist, for instance, where the two health systems have integrated programs such as home health and hospice, long-term care and rehab, or where post-acute care networks have been developed for

more strategic management of patient care with agreed upon protocols and effective hand-offs. However, many of these relationships could benefit from a coordinated approach to care.

Regional Penetration: There are scores of such providers throughout the Geographic Service Area which share important roles in the non-acute care of patients.

Ballad Health Strategy: Ballad Health will work to establish a shared information network with these non-acute care providers and to establish a best practice set of protocols for the management of patients. The protocols will solidify Ballad Health's relationship with the providers that commit to a shared approach to best practices. Ballad will expand on Mountain States current preferred SNF network to include discharges from previous Wellmont hospitals. This approach has demonstrated outcomes for reducing readmissions and improving care outcomes across the continuum of care[6] and will be mutually supportive for these providers, Ballad Health, and managing physicians, especially where payers are aligning incentives, such as around the avoidance of re-admissions.

D. Behavioral Health and Substance Abuse Providers

Current Status: Behavioral health providers in the Geographic Service Area include Wellmont and Mountain States, which provide the inpatient behavioral health services in the region, and Frontier Health and Highlands Community Services, which provide the majority of outpatient services in the area, along with a host of independent practitioners. Both health systems have relationships for the management of crisis patients and those in need of inpatient placement, most notable are the relationships with Frontier Health. Good partnerships exist and significant work has been done to strengthen the care pathways for patients, but much progress still needs to be made. As with most of the country, the Geographic Service Area is under-resourced and under-staffed. While progress is being made on the integration of primary care and behavioral health, the full continuum of care would benefit from further integration. Both outpatient and inpatient resources for behavioral health and addiction are in significant demand.

Regional Penetration: Overall, behavioral health resources in the Geographic Service Area are not sufficient or not sufficiently aligned to meet needs, especially in the rural areas. Most available behavioral health resources are concentrated in the more populated areas, and crisis stabilization for patients is difficult overall, but especially in the rural areas. Inpatient resources are located in Johnson City, Tennessee at Woodridge, which is operated by Mountain States and at Ridgeview in Bristol, Virginia and Bristol Regional Medical Center, both operated by Wellmont. Inpatient behavioral health units are also operated at Russell County Medical Center in Lebanon Virginia, Dickenson County Community Hospital in Clintwood, Virginia, and Takoma Regional Hospital in Greeneville, Tennessee. Despite the rampant substance abuse issues in the area, there is currently no regionally cohesive strategy for best-practice outpatient or inpatient substance abuse treatment and rehabilitation.

[6] *See* Melanie Evans, *Hospitals select preferred SNFs to improve post-acute outcomes*, MODERN HEALTHCARE (May 9, 2015), *available at* http://www.modernhealthcare.com/article/20150509/magazine/305099987.

Ballad Health Strategy: Ballad Health plans to make a major investment in behavioral health and substance abuse resources in the Geographic Service Area. As outlined in the Application, Ballad Health has committed $140 million towards the expansion of needed services which includes $85 million for mental health and addiction recovery.[7] This approach will require working closely with regional partners such as Frontier Health and others to develop and resource a comprehensive plan for prevention, crisis intervention and stabilization, accessible outpatient resources and community support, and needed inpatient resources—all working in a more effective and cohesive continuum of care.

II. Public Sector Partners

Public sector partners include public pre-school, primary, secondary, and higher education institutions, public health, local and state governments, county commissions, local health councils, public health departments, community service boards, economic development agencies, housing and welfare agencies, courts, and law enforcement agencies.

Current Status: As with private sector partners, these organizations work in important ways to meet community needs which contribute to health outcomes and have existing partnerships with the two health systems, but currently, the overall efforts are disjointed and not centered on common goals and objectives.

Regional Penetration: Organizations operating in the public sector span the region and reach thousands of individuals and families through a variety of social and educational services.

Ballad Health Strategy: Ballad Health will include public sector partners in (i) the development of the Community Health Improvement Plan, (ii) the Academics and Research Plan and (iii) in the formation, governance, and operation of the Accountable Care Community. Public Schools will be especially important to the prevention efforts of Ballad Health, and strong relationships already exist with many of these schools for the provision of tele-health services for clinics, exercise equipment and training, pre-diabetes assessment and education, and walking and reading programs. It will be critical for Ballad Health to work with the public sector to leverage new and existing spending and resources. Certain public sector partners will have significant involvement with Ballad Health. While the Tennessee Department of Health will be the primary public agency responsible for regulation and active supervision of the COPA, the expertise and partnership of regional health departments will be essential to informing and guiding the work of the Accountable Care Community. Local public health offices can have a significant role in development of the needs assessment, performance measurement and improvement, health promotion, and patient engagement necessary for a successful Accountable Care Community. They may also be able to assist with the collection of population health data related to risk factors and disease incidence, and provide technical assistance in reporting quality performance measures. The College of Public Health at ETSU will also have a central partnership role in the establishment of the Academic Medical Center model, the shared research infrastructure, which will be instrumental to studying the population health and community health improvement measures enacted under the COPA and in attracting translational research funding from outside sources. The Academic Medical Center model will be integrally connected to the overall plan for Academics and Research but will have its own plan and budget with the goal of advancing research collaboratively with Ballad Health and ETSU. This

[7] *See* Response to Questions Submitted April 22, 2016, for a more detailed description of this commitment.

will ensure new economic opportunities and research findings for the region. By working with the public sector partners, Ballad Health will be able to provide a range of services to the population, including population-based primary prevention services, support for minority health initiatives, support for primary care providers, oral health, pharmacy, disease screening, and home healthcare services.

III. Private Sector Partners

Private sector partners include a variety of non-profit and academic institutions including United Way agencies, Chambers of Commerce, businesses, faith-based organizations, relief agencies, food pantries, family support agencies and the like, along with local private schools, colleges, and universities.

Current Status: Wellmont and Mountain States have important relationships with these organizations, including board membership, financial support, and key partnerships. Some of the more integral relationships include the provision of clinical educators or adjunct faculty members for private nursing programs or physician assistant programs, or fully integrated residency programs, as in the case of the existing partnerships with the Debusk College of Osteopathic Medicine and the Via College of Osteopathic Medicine. In many cases, the health systems are founding or sustaining partners for community organizations dedicated to health improvement - such as Healthy Kingsport, a regional health improvement organization, or Project Access, which provides regional access to specialist physicians and case management services along with navigation services. There are many other examples. This work is important, but today, much of it is disconnected and lacks cohesive regional strategy.

Regional Penetration: Organizations operating in the private sector span the region and reach thousands of individuals and families with a variety of social and educational services.

Ballad Health Strategy: Ballad Health's strategies in the private sector are similar to its strategies in the public sector. Ballad Health will focus on three strategic directions with private sector partners (i) the development of the Accountable Care Community and the Community Health Improvement Plan, (ii) the development of the Academics and Research Plan, and (iii) the development of integral relationships with businesses, schools, and faith-based organizations to implement prevention strategies. Through the formation of the Accountable Care Community, Ballad Health will identify essential private sector partners and outline the key contributions each will commit to making in support regional systems for community health improvement. These partners will be engaged in the development and implementation of the Community Health Improvement Plan, and Ballad Health will work to scale best efforts and increase capacity through the committed $75 million investment with a focus on those which align most closely with community health improvement goals. Ballad Health has also committed to working with existing academic partners to identify needs for clinical education and graduate medical education to increase the pipeline of nursing, allied health, and physician professionals serving in the area through an $85 million investment in Academics and Research. Finally, Ballad Health will work with regional businesses, faith-based organizations and schools to extend prevention education and resources in order to help reduce health risk in populations. These efforts will include the provision of onsite, tele-health, and embedded resources such as health coaches and health educators.

IV. Payers

Payers and healthcare providers are complementary but distinct stakeholders. Payers can advance population health by creating a financial model that incentivizes physicians and delivery systems to

focus on better health, affordability and patient experience. These relationships will be critical to the move from fee-for-service to value-based reimbursement.

Current Status: Wellmont and Mountain States work with government and private payers, including self-insured companies and insurance carriers, to serve those covered under their plans. Though the historic relationship has been between payer and payee, the relationship is evolving to a more integral level of partnership. As incentives to manage the care of patients evolve into savings in pay for performance models, Ballad Health will become more involved with employers in helping to manage the health risks of employees proactively through various business health departments.

Regional Penetration: A very high percentage of existing patients are Medicare and Medicaid patients or are patients covered by managed care plans for those agencies. The majority of commercial beneficiaries in the region participate in employer-based plans or through third-party administrator arrangements offered by Humana, Cigna, BlueCross BlueShield of Tennessee, Anthem, or United. Wellmont and Mountain States participate in all of these plans and the vast majority of these plans include both health systems in their networks.

Ballad Health Strategy: The goal of Ballad Health is to move from the traditional payer-payee relationship to a partner role where the goals of the health system and the payer are aligned. This will result in shared savings for both the payer and Ballad Health through improved efficiency and quality of care. Ballad Health will work with payers to align systems of prevention and education to reduce both the incidence and progression of disease and to keep those populations it serves well. Ballad Health's aim is to create a fourfold relationship that includes Ballad Health, its physician partners, patients/beneficiaries, and payers to develop a cohesive set of strategies around population health improvement. With a relatively small number of major payers and a regionally integrated delivery system, Ballad Health has a phenomenal opportunity to align goals, incentives, and resources to support the singular goal of community health improvement in the Geographic Service Area. Payers, including insurance companies and businesses, will be invited to play an essential role in the development of the Community Health Improvement Plan and the Accountable Care Community.

RESPONSE BY APPLICANTS

TO SUBMISSIONS OF

FEDERAL TRADE COMMISSION STAFF,

AMERIGROUP TENNESSEE INC.,

PROFESSORS AND ACADEMIC ECONOMISTS,

KENNETH KIZER, M.D., MPH, AND

HOLSTON MEDICAL GROUP

TO THE TENNESSEE DEPARTMENT OF HEALTH

REGARDING

CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION

Pursuant to Tenn. Code Ann. § 68-11-1301 *et seq*.
and the regulations promulgated thereunder at Tenn. Rules & Regs. 1200-38-01-.01 *et seq*.

Submitted by:	Mountain States Health Alliance Wellmont Health System
Date:	December 19, 2016

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I. INTRODUCTION

Mountain States Health Alliance and Wellmont Health System ("the Parties") submit this response to address the submissions by the Federal Trade Commission Staff (the "staff"), Amerigroup Tennessee Inc. ("Amerigroup"), Professors and Academic Economists (the "Academics"), Kenneth Kizer, M.D., MPH ("Kizer"), and Holston Medical Group ("HMG") (collectively, the "Commenters") to the Tennessee Department of Health (the "Department") regarding the Parties' Application for a Certificate of Public Advantage ("Application"). As discussed below, these comments lack merit and do not overcome the compelling reasons for issuance of a Certificate of Public Advantage ("COPA") in this matter.

In passing the Hospital Cooperation Act of 1993, the Tennessee General Assembly approved a policy to improve the welfare of Tennesseans by encouraging integration among health care providers, even in anticompetitive transactions, if the overall net effect is to facilitate "further improvements in the quality of health care for Tennessee citizens, moderate increases in cost, improve access to needed services in rural areas of Tennessee and enhance the likelihood that smaller hospitals in Tennessee will remain open in service to their communities":

> Technology and scientific developments in hospital care have enhanced the prospects for further improvement in the quality of care provided by Tennessee hospitals to Tennessee citizens. The cost of improved technology and improved scientific methods for the provision of health care is significantly responsible for increasing the cost of hospital care. Cost increases make it increasingly difficult for hospitals to offer care to Tennessee citizens. Existing law has constrained the ability of hospitals to acquire and develop new and improved equipment and methods for the provision of hospital and hospital-related care. *Cooperative agreements among hospitals in the provision of hospital and hospital-related services may foster further improvements in the quality of health care for Tennessee citizens, moderate increases in cost, improve access to needed services in rural areas of Tennessee and enhance the likelihood that smaller hospitals in Tennessee will remain open in service to their communities.* Hospitals are in the best position to identify and structure voluntary cooperative arrangements that enhance quality of care, improve access and achieve cost efficiency in the provision of care. Because competition is important to the health care sector and some cooperative agreements may have anti-competitive effects that would operate to the detriment of the public, oversight is necessary to ensure that the benefits of the agreements outweigh any disadvantages attributable to any reduction in competition likely to result from the agreements.[1] (emphasis added).

Nineteen months ago, the Tennessee General Assembly reaffirmed that policy in its revision to the Hospital Cooperation Act.

> It is the policy of this state, in certain instances, to displace competition among hospitals with regulation to the extent set forth in this part and to actively supervise that regulation to the fullest extent required by law, in order to promote cooperation and coordination among hospitals in the provision of health services and to provide state action immunity from federal and state antitrust law to the

[1]Hospital Cooperation Act of 1993, Tennessee Laws Pub. Ch. 331 (1993).

fullest extent possible to those hospitals issued a certificate of public advantage under this section.[2]

The General Assembly's action to maintain this policy is a response to its understanding of the uniqueness of various regions of the State, and its preference that solutions to these problems reflect that uniqueness. For example, a 2015 Department report[3] found that all the Tennessee counties in the geographic service area (the "Geographic Service Area") of the New Health System (the "Tennessee Counties") exceed the national average for smoking, and seven of the ten Tennessee Counties exceed the State average for smoking. The State's obesity rate exceeds the national average, and several of the Tennessee Counties have obesity rates of more than 30 percent. All of the Tennessee Counties exceed the State average for physical inactivity (30 percent). Low birthweight is also an issue of concern. According to the same report, three of the Tennessee Counties are in the bottom third (worst group) for frequency of low birthweight births, and three of the Tennessee Counties are in the bottom third (worst group) for teen pregnancy rates. Physical inactivity, obesity, tobacco abuse and substance abuse are major health challenges that disproportionately impact residents of the Tennessee Counties, and are associated with other health challenges and conditions. The Parties' Application reported key statistics on the population in all Tennessee Counties in the Geographic Service Area, and Tennessee State-wide averages for physical inactivity, obesity, tobacco use, and substance abuse. (Application, Table 8.2 at 33)

The General Assembly not only recognizes that solutions to these challenges may be regional in nature, but also that such solutions may call for immunity from state and federal antitrust law *to the fullest extent possible*. The Tennessee Counties served by the Parties face significant challenges in sustaining the health care infrastructure, and some of the hospitals in this rural area face negative operating margins. The hospitals that support these rural hospitals are facing downward pressure on their own operating margins, calling into question their ability to continue supporting these rural hospitals and access points. For instance, prior to the announcement of the merger, because of these financial challenges, each system was in the process of reducing the number of funded residency positions. The State has a compelling interest in the training of physicians in rural areas, and this region was facing a reduction in the pipeline of future physicians.

The Application submitted by the Parties directly and explicitly addresses each element of the Hospital Cooperation Act and its implementing regulations. By way of example, the Parties are proposing to guarantee that all rural hospitals will remain open as health care facilities, a promise that the Parties cannot make in the absence of the proposed merger and that directly supports the policy stated in the Hospital Cooperation Act. The proposed investment in outpatient mental health, residential addiction recovery and expansion of pediatric services, for example, improve access to needed services in this rural area—again, directly to the point at law. Incremental new investment in population health, dollars that will not be available but for the merger, to focus care management on high utilizers with chronic conditions is intended to directly address the law's requirement for fostering improvements in the quality of health care.

[2]Tenn. Code Ann. § 68-11-1303 (effective May 18, 2015).

[3]TENNESSEE DEPARTMENT OF HEALTH, DIVISION OF POLICY, PLANNING, AND ASSESSMENT, 2015 DRIVE YOUR COUNTY TO THE TOP TEN (July 2015), *available at* https://www.tn.gov/health/topic/specialreports.

Addressing these issues in order to improve health, access, cost, quality and outcomes are among Tennessee's highest priorities and are central to the law. The region's poor health and the associated costs are not sustainable, and approval of the Application provides a "unique solution for a unique region." (Application at 8)

The Commenters' submissions only tangentially refer to the specific geography, population, and health issues facing Northeast Tennessee area, of which the Parties have firsthand knowledge and which the Application details and addresses.[4] For example, ***the 10 counties in the Geographic Service Area served by the New Health System in Northeast Tennessee are largely rural with disproportionately low educational attainment levels and high levels of poverty***.[5]

The Application and the commitments therein are intentionally aligned with the issues that are most important for the residents of the Geographic Service Area and that are fundamental drivers of the cost of health care. The Parties share the State's and the Department's concerns about these significant health challenges. These issues are among the key areas of focus for the Community Health Work Groups formed as a result of the proposed merger which have informed the work of Mountain States and Wellmont throughout this process. The Commenters do not address, or even appear to recognize, these critical priorities that form the baseline for concerted action and investments by the Parties under the continuing supervision of Tennessee, and the Commenters lack of commentary on these issues lays bare the disconnect between the Commenters' opposition to the State's policy goals and their own goals.

Challenging health conditions combined with external factors as outlined below, create tremendous financial pressure for rural hospitals and make it difficult to sustain inpatient services. These damaging health outcomes disproportionately impact the poor and add to the substantial burden that rural facilities already bear, including disproportionate levels of uncompensated care and Medicaid, inability to recruit and retain physicians, gaps in services available external to the hospital and fixed cost structures required to keep the hospitals operating. Historically, Wellmont and Mountain States have supported their rural hospitals financially with both capital investment and operating support, and most of their rural hospitals operate with negative or very low operating margins. Staff assume that because this financial support has existed in the past, each of the systems can and will continue such support in the

[4]These challenges were addressed in more detail, for example, in Section 8 of the Application and are among the priority items for the New Health System in its plans for integrated delivery system and improving access to and coordination of care across the region. Among the many issues confronting the area are its significant prevalence of chronic conditions and health behaviors, such as diabetes, tobacco use and substance abuse in counties that are largely rural. This is even more starkly evidenced by reference to more detailed data in the Tennessee Department of Health: Division of Policy, Planning, and Assessment's "2015 Drive Your County to the Top Ten" report and confirmed further in its 2016 Report. TENN. DEP'T OF HEALTH, DIV. OF POLICY, PLANNING, AND ASSESSMENT, 2015 DRIVE YOUR COUNTY TO THE TOP TEN (July 2015), *available at* https://www.tn.gov/health/topic/specialreports. *See also* TENN. DEP'T OF HEALTH, DIV. OF POLICY, PLANNING, AND ASSESSMENT, 2016 DRIVE YOUR COUNTY TO THE TOP TEN (May 2016), *available at*

https://www.tn.gov/assets/entities/health/attachments/Drive_Report_2016.pdf. The Report provides health status, demographics, and other metrics on health for each Tennessee county and identifies priorities for health issues and action items to drive positive change. The Report ranks each county in Tennessee relative to other Tennessee counties and compares each to the state average and to three representative "peer" counties. The comparisons largely focus on health status and health behaviors such as tobacco use, obesity, and the residents reporting poor or fair health.

[5]The statistics for all of the counties in the Geographic Service Area may be found in Exhibit 8.1A of the Application for COPA, State of Tennessee.

future. *Without the synergies resulting from the merger, there should be no such assumption*. In 2015, Mountain States and Wellmont collectively shouldered the burden of $19.5 million in operating losses in their small rural community hospitals. As operating margins in the larger Mountain States and Wellmont facilities continue to face downward pressure due to declining inpatient use rates, it is becoming more challenging to continue carrying these losses. This is why the commitment to continue operating these facilities as health care institutions is such an important commitment. Without such a commitment, there is no such guarantee.

Most of the Parties' Tennessee rural hospitals currently have an average daily census of twenty patients or less, with licensed bed occupancy at these hospitals ranging from 0.1 percent to 30.9 percent.[6] The populations of the Tennessee Counties are declining or stagnant, and this trend is expected to continue. The economic strain on the Parties is serious and must be addressed, because the Parties' survival is crucial for the residents in these rural counties to have access to medical care. In addition to the operating losses of their rural hospitals, Wellmont and Mountain States have accumulated nearly $1.5 billion of debt as a result of redundant costs for duplicating each other's services and programming. This significant duplication of costs and health care services in the region is not sustainable and places the Parties' rural hospitals in danger. The Parties are not alone in these experiences. According to the University of North Carolina Sheps Center, 78 rural hospitals have closed since 2010, including eight in Tennessee and one in Virginia,[7] and more than 600 could be vulnerable going forward.[8]

Despite these realities, staff and other critics try to make their case against approval of the Parties' Application by arguing that the merger is anticompetitive under a traditional antitrust analysis. This antitrust focus is misplaced and ignores the very reason the Parties are seeking active state supervision. The policy expressed in the Hospital Cooperation Act to facilitate the provision of quality, cost-efficient medical care to Tennessee's rural patients is of such high importance to the General Assembly that the law *encourages* mergers and offers "state action immunity from federal and state antitrust law *to the fullest extent possible*[.]" (Emphasis added) In those instances, the General Assembly's intent is "to displace competition among hospitals with regulation[.]"[9] Staff make clear that they disagree with the Legislature's policy choice to institute a regulatory program that supplants competition with respect to health care transactions for Tennesseans. Repeatedly, staff's disagreement with the concept of cooperative agreements permeates their and others' commentary about the merits of the Parties' Application. *Staff's policy opinions are not relevant*. Under longstanding U.S. Supreme Court doctrine, a sovereign

[6] *See* Application for COPA, State of Tennessee, Tables 5.2 and 5.3.

[7] *See* THE CECIL G. SHEPS CENTER FOR HEALTH SERVS. RESEARCH AT THE UNIV. OF N.C. (as of December 17, 2016) ("80 Rural Hospital Closures: January 2010 – Present") (Fourteen rural hospitals have closed since the Application was filed in February, 2016, including two rural hospitals in Tennessee.), *available at* https://www.shepscenter.unc.edu/programs-projects/ruralhealth/rural-hospital-closures/.

[8] *See Id.*; iVANTAGE HEALTH ANALYTICS, 2016 RURAL RELEVANCE: VULNERABILITY TO VALUE (2016) (assessing rural and Critical Access Hospital performance), *available at* http://www.chartis.com/resources/files/INDEX_2016_Rural_Relevance_Study_FINAL_Formatted_02_08_16.pdf; Alyssa Ellison, *The rural hospital closure crisis: 15 key findings and trends*, BECKER'S HOSPITAL CFO (Feb. 2016), *available at* http://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html; *and* BG Kaufman et. al, *The rising rate of rural hospital closures*, 32(1) J. OF RURAL HEALTH 35-43 (2016).

[9] Tenn. Code Ann. § 68-11-1303.

state policy is beyond the reach of federal antitrust laws. See *infra* at Section III for a more detailed discussion of this point.

The merged health system would operate in a regulated program that places strong constraints on exercise of market power contrary to the commitments within the COPA. Staff take inadequate account of the substantial regulatory restrictions to which the Parties will be subject. Critics' comments regarding these and other features of the Cooperative Agreement also repeatedly ignore facts that do not support their narrative to oppose cooperative agreements at all costs. Among other things, the merged system will be subject to a cap on rate increases to reduce the pace of health care cost growth; conduct restrictions; commitments to invest hundreds of millions of dollars into initiatives for improving quality, access and population health: and regular reporting requirements and other accountability mechanisms to government officials who not only actively supervise compliance with the commitments but also can institute proceedings to terminate the Cooperative Agreement if needed.

In contrast to staff's and other critics' assessments, the Parties are aware of the many letters and statements submitted for the record to the Department by a variety of business, government and community leaders who, based on their own conclusions, support approval of the Application. These individuals represent companies, municipalities, consumers, employees and families directly affected by this decision as the actual purchasers of the services. That they have taken the time to educate themselves on the proposal, and have engaged with the State Government, speaks volumes about the level of community interest in this endeavor. It also speaks to the transparency and inclusiveness of the process. This engagement should carry significant weight in the Department's consideration.

A few examples of commentary which speak to these issues come from area employers, government officials and residents who offer their own educated views of the situation:

> *"In 2014, the Washington County Commission itself acknowledged the risks in the health care sector unanimously passing a resolution expressing their support for maintaining local control. I'd like to share just a small portion of the resolution:*
>
> > *'Whereas regional access to quality health care systems that are responsible to our local population health challenges and focus on clinical excellence is integral to the overall desirability of this region, or ability to attract employers and new investment, and to improving the quality of life for our citizens; and*
> >
> > *Whereas health care is the largest provider of jobs in Washington County, Tennessee, providing a significant direct impact on the economy of this region; now*
> >
> > *Therefore, be it resolved that we strongly encourage the Boards of Directors of our local health care systems to carefully consider the impact of their decisions on the quality and availability of the comprehensive health care services currently accessible in this region and the economic impact likely to result from the loss of local control.'*
>
> *And so they did. I'm here this afternoon as a local elected official, very thankful to the boards of Wellmont and Mountain States for making a commitment to this region that has resulted in a planned merger that I believe is a best-case scenario*."
>
> Dan Eldridge, Mayor, Washington County
> June 7, 2016 Public Hearing

"I wholeheartedly support the COPA and the potential the merger has to improve health and healthcare in our region. I am currently an active volunteer in the Wellmont system but prior to my retirement in 2011 I was the Chief Administrative Officer and President of the Eastman Foundation at Eastman Chemical Company. In those roles I had many opportunities to interact with both the Mountain States and Wellmont Health Systems and their leadership. As a company in the region with many covered lives and concerned about the growth in health care costs, it was abundantly clear to me and my Eastman team that the sub optimization and redundancies across the systems and that of other medical groups was only making it more difficult in the long run to have sustainable high quality health care in the region.

Based on all of my business and personal experiences, I believe the merger has the potential to ensure a better allocation of resources in the region with no detrimental effects on our current high quality of care. I also believe the merged entity can also develop and execute a more robust long term strategic plan to better benefit the long term health needs for our region. It is primarily for these reasons I support the merger. We live in a world of limited resources so we cannot afford to misallocate them. I just wish we could have gotten to this point several years earlier."

Norris Sneed, Retired/Former Chief Administrative Officer, Eastman Foundation
Public Comment to Tennessee Department of Health – August 15, 2016

"A merged health system would enable our region to increase the velocity of change necessary to address obesity and diabetes rates that are higher our region than the state and national averages."

"The path forward is clear. We, as concerned citizens, must have the courage to embrace it. I ask that you support the state. I ask that you grant a Certificate of Public Advantage to Wellmont Health System and Mountain States Health Alliance."

Kandy Childress, Executive Director, Healthy Kingsport
June 7, 2016 Public Hearing

"I wholeheartedly believe a well-structured partnership between our two excellent local health care systems will create a healthy, viable, and sustainable local health care system, one that will retain local ownership governance and will allow the combined entity to continue to make a positive impact on our region's health and economic well-being."

Ken Maness, Commissioner, Tri-Cities Regional Airport (Long-time Business Person/Retired)
June 7, 2016 Public Hearing

"I feel the merger between Mountain States Health Alliance and Wellmont Health System would benefit the community in many ways. One of which is having access to specialized care within our community. Today many of our patients and their families are traveling out of the area to receive the care they desperately need. This imposes hardships, greater out of pocket expenses and often they are separated from their families. When the hardships are too much for some to bear, they are faced with making unquestionable decisions as to whether they seek the care they need or not. We all heal better when we are near those who love and care for us the most. With the proposed merger and plans to expand services in our community, we will all WIN."

Sandra Bailey
Public Comment to Tennessee Department of Health – September 7, 2016

"The combined system with expanded resources and a larger footprint will create a new opportunity and potential for real and measurable success. Combined with East Tennessee State University and the vast array of resources available through the university and the medical school, we will have access to one of, if not, the best network and system in the country to really move the needle towards creating a healthy region."

Charles W. Glass – CEO, Greater Kingsport Family YMCA
Statement of Support, compiled October 27, 2015

"I am fortunate to know personally many of the leaders of both health care systems. I know them as people of integrity who care deeply for our region and our people. They have arrived at the best decision for the people of our region through the proposed merger and I am happy to support it."

Marvin Cameron – Pastor, First Baptist Church
Statement of Support, compiled October 27, 2015

"The New Health System would lead to more manageable costs for employers, while still allowing employees to get the care that they need. In order to remain competitive in the current climate shaped by the economic conditions, demographics, and government policy changes, a health care system must proactively focus on managing costs, improving quality, and finding efficient and innovative ways to improve operations and services. Eastman believes the proposed merger could allow the New Health System to continue to make available and affordable high quality health care in the region."

David Woodmansee, Johnson City, TN, Eastman Chemical Company, Vice President, Assistant General Counsel & Assistant Secretary
June 7, 2016 Public Hearing

"Our executive management of the bank, our board, we've discussed this extensively. As an employer, we unanimously support it. We've evaluated the COPA and its impact on our objectives for the health and well-being of our employees and their families. We've evaluated the competitive aspects of multiple systems, and we've to the conclusion that the continued arms race of the past has produced a costly system with sub-optimal utilization.

We think that that the upside benefits of cooperation will bring us better outcomes, faster EMR adoptions, and the opportunity for the adoption of leading-edge technology that remaining separate wouldn't bring."

Roy Harmon, Chairman and CEO, Bank of Tennessee
June 7, 2016 Public Hearing

"Our chamber board spent as much time as any community group could scrutinizing what we're talking about today. And we unanimously, after our own due diligence, said that this merger would be extremely beneficial."

Gary Mabrey, President and CEO,
Johnson City/Jonesborough/Washington County
Chamber of Commerce
June 7, 2016 Public Hearing

"I would like to offer a few comments of support for the proposed merger between Mountain States and Wellmont. As a business leader in the Bristol market, I see distinct advantages in allowing our two local health systems to combine. Below are just a few I would like to highlight:

1) Local control of our health care
2) Combination / enhancements of specialties and the ability to develop sub-specialties not now available in our market
3) Increased focus on our population heath management in conjunction with ETSU
4) Maintaining / enhancing our extensive regional health care delivery network
5) Cost control thru elimination of duplicated services, corporate overhead and compliance with the COPA guidelines."

David Wagner, Market President for Bristol and
Blountville, Bank of Tennessee
Public Comment to Tennessee Department of Health
– August 5, 2016

"The merged system and its proposed investments in the region's higher educational partners, including, but not limited to ETSU, will bring together two of the region's strongest assets. By investing in health professional education, the merged systems will be helping to assure the quality of healthcare for the future of the region, and, at the same time, supporting one of the region's largest employers—a true "win-win" for our region. Given the health challenges facing central Appalachia, I believe that strong region-wide health system, and an equally strong Academic Health Science Center, could position the region as a highly attractive location for health and education-related investments."

Dr. Randy Wykoff, Dean, ETSU College of Public
Health
Public Comment to Tennessee Department of Health
– August 5, 2016

"Combining strengths, assets and liabilities would enable these systems to focus more on quality, population health management, mental health programs and other services benefiting the entire region."

Douglas J. Springer, MD, immediate past president
of the Tennessee Medical Association
Better Together Website

"The Tennessee Nurses Association embraces the decision as one that will improve the quality of health care in our region, control spiraling costs, and better address the chronic health care issues facing this state."

Teresa A. Martin, MSN, FNP-BC, District President,
on behalf of District 5, Tennessee Nurses Association
Better Together Website

"In a part of the state that cannot afford it, these competing hospital systems are having to spend for advertising and "keep up with the Joneses" spending on programs. Flashy items that attract patients (cardiology) receive funding and attention while needed programs in mental and behavioral health go wanting. Having one system responsible for the health of the region will provide the economies of scale we need, and it will eliminate waste while allowing for investment into effective programs in the community. I am strongly in favor of the COPA and merger."

Dr. Jeff Summers, Internal Medicine, Mountain
States Health Alliance
Public Comment to Tennessee Department of Health
– August 9, 2016

"I am writing to support the issuing of the COPA, because I see that the health care needs of our local communities are in many ways unique and I feel that the benefit of keeping local control over how we allocate our resources will better served than if we have to merge or be purchased by some outside institution. I understand that there are risks to the concept of a monopoly but healthcare is far, far from a typical free enterprise and the pressures to keep costs/expenses controlled are greater in today's healthcare markets than they were in the past or in most other businesses."

Dr. Glenn Birkitt, Independent Physician, Wellmont
Bristol Regional Medical Center
Public Comment to Tennessee Department of Health
– August 14, 2016

II. OVERVIEW OF THE MERGER

Two years ago, Wellmont began an internal evaluation of its strategic and financial position, industry trends and the organization's goals for the future of health care within its service area. Wellmont entered the process from a position of clinical strength and relative financial stability, but recognized that it needed to be prepared for financial pressures, regulatory mandates and imperatives for change. The important and increased need for investment in population health, management of information and measurable improvement in cost and quality, combined with continued downward pressure on reimbursement from government and commercial payers, compelled the Wellmont Board to thoroughly evaluate its strategic options. Wellmont's Board evaluated all reasonable options with the objective of sustaining community assets vital to the region while achieving high-quality patient care at the lowest possible cost. Wellmont was not alone. Hospital systems throughout the nation have undergone strategic options reviews, with many choosing a traditional merger or consolidation in hopes of surviving in this challenging environment. Four of Wellmont's six hospitals are rural and have fewer than 50 staffed beds, each with a daily census ranging from 3 to 13. Seven of the Mountain States hospitals are rural and have fewer than 50 staffed beds, each with a daily census ranging from 1 to 35. The overwhelming number of assets between the two systems are rural.

While providers throughout the nation have faced challenges that led them to merge with out-of-market entities or to be acquired, Wellmont and Mountain States face a challenge somewhat different. The region's declining inpatient use rates and a population that is projected to remain stagnant (and even decline in many of the Parties' markets), combined with the second lowest Area Wage Index in the United States (making Medicare and Medicaid reimbursement, which represent 70 percent of the payer mix, among the lowest in the nation), the region's hospitals face a scenario in which any out-of-market acquiring entity will most likely have no choice but to seek higher pricing in order to sustain operating margins. Any system acquiring Mountain States or Wellmont would need to generate the incremental revenue to offset the nearly $1.5 billion in debt they would be absorbing, even in the face of deteriorating patient volumes, to sustain the cost of duplicative services. The only place to look would be to leverage the less than 20 percent of the payers that pay negotiated rates for additional reimbursement. Since Medicare and Medicaid reimbursement in the region is among the lowest in the nation, and since most negotiated commercial reimbursement is tied to Medicare payments, it is highly likely that any potential acquiring entity would have payment rates higher than either Wellmont or Mountain States. Certainly, it would be in Wellmont and Mountain States' interest to identify such a partner and to utilize its capacity to generate this incremental revenue in order to be assured the hospitals would have the requisite margins going forward. It should also be assumed that any entity would look to close money-losing services or hospitals, creating additional major gaps in care. This is not simply conjecture on the part of the applicants. There is a reason 78 hospitals have closed, and hundreds more are at risk.

After a thorough evaluation, Wellmont's Board of Directors and leadership team ultimately determined that Wellmont's future would be best served through a strategic alignment with another health care system. In April 2014, Wellmont began a strategic options process to further consider alternatives to fulfill its long-term health care mission through potential alignment options. Wellmont engaged with twenty-two organizations, issuing requests for proposals from health systems interested in strategic alignment. Wellmont received substantial interest from a variety of sophisticated health systems, ultimately receiving nine proposals from other health systems, including Mountain States. After more than a year of merger discussions,

internal analysis within each system, thoughtful conversations in the community and unanimous votes by both boards to examine this option, Wellmont entered into a term sheet with Mountain States in April 2015 to exclusively explore the creation of a new, integrated and locally governed health system (the "New Health System").

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

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

III. RESPONSE BY APPLICANTS

TO SUBMISSION OF

FEDERAL TRADE COMMISSION STAFF

A. Staff's Policy Objections Are Not Relevant

The Tennessee General Assembly (the "Legislature") has clearly articulated and affirmatively expressed the policy of the State to supplant competition with regulation for cooperative agreements, including mergers, that meet the statutory requirements of the Hospital Cooperation Act (the "Hospital Cooperation Act" or "Act"). Staff clearly believe Tennessee's policy for improving health care conditions in the State is misguided.[1] They contend "[c]competition is the most reliable and effective mechanism for controlling health care costs while preserving quality of care, including in rural areas facing economic challenges." (staff comments at 2) They argue that "[c]ompetition is no less important in rural and economically stressed communities than it is in urban and more prosperous ones." (*Id.* at 10) They provide FTC Chairwoman Ramirez's remark that the goals of improving health care quality and cost "are best achieved when there is healthy competition in provider markets." (*Id*. at 1 n.5) Repeatedly throughout their submission, staff interject their unwavering policy bias into comments ostensibly directed to the merits of the Parties' Application under the Hospital Cooperation Act.

Staff's disagreement with Tennessee's public policy choices has no relevance to this proceeding and should be given no weight. The Legislature's decision to enact the Hospital Cooperation Act is solely within the sovereign purview of Tennessee. Over seven decades ago, in *Parker v. Brown*, 317 U.S. 341 (1943), the U.S. Supreme Court held that Congress did not intend the federal antitrust laws to apply to states acting in their sovereign capacities. Tennessee acted in its sovereign capacity when the Legislature originally passed the Hospital Cooperation Act and the Governor signed it into law in 1993. The Legislature and the Governor reaffirmed the State's policy choice in 2015 when they materially amended the Hospital Cooperation Act. Staff's opinion that competition is always and forever a better policy for Tennesseans than the regulatory model encompassed in the Hospital Cooperation Act is legally irrelevant. Staff's argument seems intended to prioritize staff's policy views over the distinctly different sovereign policy that is clearly articulated in Tennessee law. Further, this sovereign policy is outside the scope of staff's expertise.[2]

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[1] As staff point out, their comments do not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. (staff comments at n.1)

[2] A recent Federal Trade Commissioner herself recognized that the agency does not possess sufficient information to opine on non-competition-related public policy goals of state laws that restrict competition. In a January 8, 2016, dissent to a FTC and Dept. of Justice joint statement on repeal of the South Carolina Certificate of Need statute, then-Commissioner Julie Brill states:

> "My concern is I do not believe the Agencies possess sufficient relevant information to opine on *non-competition*-related public policy goals of the CON laws. Our experience is broad but it does not extend to every issue. The FTC should advise South Carolina policy makers based on our area of expertise—competition—and not overstep our collective knowledge. Health care policy makers at the state level are faced with difficult issues separate and apart from the strong benefits competition brings to health care markets. These include the critically important issue of preserving access to care for the needy, and doing so in a complex market, involving informational asymmetries among patients, providers, and payers. In this context, it is important to understand that competition will not move resources from those that can afford health care to those that cannot. As the Agencies stated in 2004:
>
> > 'competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payers. Competition also will not shift resources to those who do not have them.'"

Staff's propensity to ignore this fundamental doctrinal principle is also seen in its selection of case references. Staff cite to *North Carolina State Board of Dental Examiners v. FTC*, 135 S.Ct. 1101, 1109 (2015), and the Supreme Court's statement therein that "federal antitrust law is a central safeguard for the Nation's free market structures" and is highly important to economic freedom and to the free-enterprise system. (staff comments at 5 n.18) But staff stop short of quoting to the Department the more pertinent text found in the Court's very next paragraphs:

> The Sherman Act serves to promote robust competition, which in turn empowers the States and provides their citizens with opportunities to pursue their own and the public's welfare. *The States, however, when acting in their respective realm, need not adhere in all contexts to a model of unfettered competition.* While "the States regulate their economies in many ways not inconsistent with the antitrust laws," in some spheres they impose restrictions on occupations, confer exclusive or shared rights to dominate a market, or otherwise limit competition to achieve public objectives. *If every duly enacted state law or policy were required to conform to the mandates of the Sherman Act, thus promoting competition at the expense of other values a State may deem fundamental, federal antitrust law would impose an impermissible burden on the States' power to regulate.*
>
> For these reasons, the Court in *Parker v. Brown* interpreted the federal antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity. That ruling recognized Congress' purpose to respect the federal balance and to "*embody in the Sherman Act the federalism principle that the States possess a significant measure of sovereignty under our Constitution*." *Since 1943, the Court has reaffirmed the importance of Parker's central holding*.[3]

B. Staff's Traditional Antitrust Law Analysis Does Not Respond To The Issues In The Hospital Cooperation Act

Turning to the Hospital Cooperation Act, staff contend that the Department should evaluate the Parties' Application (solely) according to the FTC's methods for merger analysis. Staff say this is appropriate because their antitrust approach is "similar to that which the Department will take when reviewing COPA applications." (staff comments at 7) Staff are incorrect. A traditional antitrust analysis does not respond to and incorporate the different Tennessee policy goals clearly articulated in the Hospital Cooperation Act.

1. State Policy, Not Antitrust Law, Governs Cooperative Agreements

The Legislature established a set of analytical factors for the consideration of cooperative agreements under the Hospital Cooperation Act distinctly different from those used by the FTC to scrutinize traditional mergers under the federal antitrust laws. The Hospital Cooperation Act

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Staff's comments are an example of the agency's representatives "overstepping their collective knowledge" and clearly lack merit in this proceeding. Former Commissioner Brill's full statement is available at https://www.ftc.gov/system/files/documents/public_statements/905323/160111ftc-doj-sclaw-statement.pdf?utm_source=govdelivery (citation omitted).

[3] *North Carolina State Bd. of Dental Examiners v. FTC*, 135 S.Ct. 1101, 1109 (2015) (citations omitted) (emphasis added).

"promote[s] cooperation and coordination among hospitals" and authorizes *approval* of anticompetitive mergers that meet the law's evidentiary tests. The federal antitrust laws *prohibit* anticompetitive mergers. This fundamental distinction is absent from staff's comments. The result is a submission replete with incorrect and unhelpful analysis that is disconnected from the Tennessee policy goals and evidentiary requirements applicable to an application for a COPA under the Hospital Cooperation Act. (See *infra* for more detailed discussion of inaccuracies in staff comments.)

Staff urge the Department and Commissioner to scrutinize the Parties' merger under the methods of the FTC-Department of Justice Horizontal Merger Guidelines (the "Merger Guidelines").[4] (staff comments at 7) The Merger Guidelines are designed to "identify and *challenge* competitively harmful mergers while avoiding unnecessary interference with mergers that are either competitively beneficial or neutral." (staff comments at 7; emphasis added) That is not the right framework for considering an application for a COPA under the Hospital Cooperation Act. The Tennessee statute does not mandate a "challenge [to] competitively harmful mergers" or even the denial of an application merely for the reason that the merger is likely to be anticompetitive. Rather, under the Hospital Cooperation Act, mergers that might be anticompetitive under the federal antitrust laws can be authorized pursuant to a policy that "displace[s] competition among hospitals with regulation . . . and to actively supervise that regulation . . . **to *promote* cooperation and coordination among hospitals in the provision of health services**."[5] (emphasis added)

The Hospital Cooperation Act establishes a program of regulation combined with active State supervision to achieve pro-consumer benefits in ways other than reliance on pure competition. The Act takes into account enhancement of quality, preservation of hospital facilities, improvements in the utilization of hospital resources, avoidance of duplication, and population health improvement, in addition to the gains in the cost-efficiency made possible by the merger. It ensures that these benefits will be realized through legally enforceable commitments from the Parties to pursue high quality performance and to invest money from merger-generated cost savings into programs that will improve population health, expand access to care, and create community benefits tailored specifically to the needs of Tennessee's patients. This is particularly important when these investments of merger-generated cost savings are helping achieve priorities of the State that would otherwise not be possible, or not be as immediate, without the merger. All of these commitments and the related actions made possible solely by the merger itself offer significant public advantage above and beyond market protections.

Active and ongoing supervision of these commitments is implemented, moreover, to ensure the New Health System's compliance with the policy goals articulated by the Legislature in the Hospital Cooperation Act that displaces competition with regulation. The Act also allows for mechanisms such as rate restrictions to ensure reasonable prices and conduct restrictions to ensure non-exclusionary practices to guard against potential adverse impacts from the reduction

[4]U.S. DEP'T OF JUSTICE AND FED. TRADE COMM., HORIZONTAL MERGER GUIDELINES (August 19, 2010) [hereinafter "MERGER GUIDELINES"], available at https://www.ftc.gov/sites/default/files/attachments/ merger-review/100819hmg.pdf.

[5]Tenn. Code Ann. § 68-11-1303(a) (effective May 18, 2015).

in competition. Staff's antitrust/Merger Guidelines analysis does not take proper account of this carefully constructed regulatory framework.[6]

2. Efficiencies In A Cooperative Agreement Are Not An Antitrust Issue

The gap between staff's analysis, which is grounded in traditional antitrust theory, and the broader, community health-centered analysis which the Department must utilize under the Hospital Cooperation Act is perhaps most pronounced with respect to consideration of the cost efficiencies and consumer and community benefits likely to flow from the Cooperative Agreement. To be clear, this is not a traditional merger analysis. The scope of potential community and consumer benefits here are far broader.

a. Efficiencies Analysis Under The Federal Merger Guidelines Versus Community Health Benefits Analysis Under The Hospital Cooperation Act

Under the Hospital Cooperation Act, even potentially anticompetitive mergers qualify for approval if the totality of consumer and community benefits, cost-savings, synergies, and other advantages from the merger (collectively herein, "efficiencies") exceed by clear and convincing evidence any disadvantages attributable to reduction in competition likely to result from the cooperative agreement.[7] The likelihood of any disadvantages can be minimized by mechanisms such as rate caps for pricing, restrictions on anticompetitive conduct, commitments for specific actions to improve quality measurably, and active supervision along with the powers to modify or withdraw approval of the COPA. As detailed herein, these "conduct" commitments are straightforward and easily enforceable by the State.

Staff's approach to efficiencies under its Merger Guidelines is focused solely on whether the claimed efficiencies enhance *competition* – not on other policy goals, such as Tennessee's policy to promote even anticompetitive mergers that convey net benefits to the community under the statutory conditions described above.[8] The FTC does not credit an efficiency unless that efficiency is "merger-specific" (likely achievable only through the merger at issue or another

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[6]According to staff, the Merger Guidelines, to which staff repeatedly refer in their submission, "reflect experience in analyzing a wide variety of mergers . . . as well as economic and other relevant research." (staff comments at 7) The "mergers" and "research" underlying the Merger Guidelines, however, do not include mergers subject to the unique factors and strict regulatory restrictions under cooperative agreement or COPA laws. *See* staff comments at 67-68 & n.291 (discussing the FTC's "difficulty in assessing whether the public policy goals of the Mission Health COPA have actually been met"). At a public hearing before the Southwest Virginia Health Authority on October 26, 2016, an FTC economist admitted that staff have never conducted an empirical analysis into the market effects of a merger subject to the regulatory restrictions of a cooperative agreement or COPA. Staff's effort to shoehorn the Parties' Application into the Merger Guidelines framework not only lacks foundation in case experience or empirical research, moreover, but also fails on the merits, as discussed in the section that follows.

[7]Tenn. Code Ann. § 68-11-1303(e)(1). The term "efficiencies" in the COPA context is broader than that used in traditional mergers and covers broader populations; for example, it can encompass effects that provide for financially sustainable and high quality care at hospital locations in an area serving all populations or changes that provide for realignment of clinical services to make effective use of scarce resources and enhance service delivery to improve outcomes and achieve improved health and reduced costs.

[8]Moreover, staff's analysis explicitly assumes that continued competition in the absence of the merger would lead to substantial efficiencies and quality that would be lost or reduced substantially by the merger. As noted, in this particular fact pattern, that assumption is inconsistent with the likely reality.

merger that is equally anticompetitive absent the efficiency) and is substantiated as to how it will "enhance the merged firm's ability and incentive to compete." (Merger Guidelines § 10) Efficiencies will persuade the FTC not to challenge a merger only if they "are of a character and magnitude such that *the merger is not likely to be anticompetitive* in any relevant market." (*Id.*; emphasis added) To make that determination, the FTC considers only whether the efficiencies "likely would be *sufficient to reverse the merger's potential harm* to customers in the relevant market." (*Id.*; emphasis added)

Staff view each of these antitrust-focused efficiency restrictions in the Merger Guidelines only through a competition lens. The restrictions operate to further the federal antitrust law's principal purpose for those mergers which are not immune, which is to *prevent* mergers and conduct that are deemed to be anticompetitive. Conversely, the purpose of the Hospital Cooperation Act, which is in full alignment with the Supreme Court's express doctrine, is to create a pathway for *approval* of mergers by the State – including those that might be seen as anticompetitive – that further the State's broader public policy objectives to enhance community health. Approval of cooperative agreements that satisfy the Act's evidentiary balancing test for benefits versus disadvantages, coupled with active supervision to ensure that the balance of net benefits is maintained is the public policy of Tennessee. Efficiencies that would not be credited under the Merger Guidelines because they would not be sufficient to reverse the merger's potential harm to competition in a specifically defined relevant market ***must*** be accorded weight under the Hospital Cooperation Act.[9]

Tennessee's Hospital Cooperation Act establishes a regulatory program that mandates consideration of a broad range of positive effects resulting from cooperative agreements, coupled with substantial checks on potential anticompetitive effects. The Act identifies preservation of hospital facilities, population health improvement and access for the medically underserved as factors which must be considered in evaluating cooperative agreements.[10] In addition, the Legislature required the consideration of ***any*** other benefits that might be identified.[11] The language of the Act clearly demonstrates the intent of the Legislature to give primacy to the achievement of community health benefits, broadly considered. This is in marked contrast with federal antitrust policy, with its one-dimensional focus on promoting competition.

Further, the Hospital Cooperation Act empowers the Department to establish conditions to its approval of a COPA. Under this model, mergers that may reduce competition can be regulated to limit sharply any risk of potential disadvantages, while enabling the beneficial attributes of substantially greater weight to flow to consumers. For example, the merged entity can be prevented from charging anticompetitive prices or engaging in exclusionary conduct. Active supervision by the Department ensures compliance with the conditions for approval.

In the case of the Mountain States-Wellmont merger, the benefits meet this test, and, due to the significance of the Parties' investment commitments, there is overwhelming economic incentive for the merged system to achieve the synergies outlined in the Application. Moreover,

[9]Tenn. Code Ann. § 68-11-1303(e)(2).

[10]Tenn. Code Ann. § 68-11-1303(e)(2)(F),(G).

[11]Tenn. Code Ann. § 68-11-1303(e)(2)(H).

the merger creates an integrated delivery system that is accountable to the State and the community with regard to its operations and results. This is a far broader set of benefits than those usually examined by staff in a traditional merger.

Thus, staff are incorrect when it argues, as it does repeatedly, that the Department's role under the Hospital Cooperation Act "is similar to the analysis that courts and antitrust agencies perform when assessing the competitive impact of mergers" using the Merger Guidelines. (staff comments at 28) The courts and antitrust agencies assess whether a merger is anticompetitive – and stop there. A traditional merger goes forward or gets blocked on that single determination. The Hospital Cooperation Act is different. It codifies a policy recognition that certain potentially anticompetitive health care mergers, when appropriately regulated and actively supervised, can yield substantial health and economic benefits to the community that outweigh the harm, if any, that may result from a lessening of competition. Nothing "similar" to that principle exists in staff's enforcement of federal antitrust law in the absence of state action immunity. The legal cases cited by staff reflect the federal antitrust requirement that efficiencies reverse the merger's anticompetitive effects. (See staff comments at 29 n.107 & n.108) If that were that the standard under the Hospital Cooperation Act, then the Legislature would not need to "provide state action immunity from federal and state antitrust law to the fullest extent possible to those hospitals issued a certificate of public advantage under this section."[12] The public policy objectives of the State of Tennessee as articulated by the Legislature in the Act are distinctly different from those of federal antitrust policy.

Staff repeatedly invoke competition-based Merger Guidelines concepts when arguing why none of the community benefits and other efficiencies described in the Parties' Application warrants meaningful weight or any weight. Those arguments are factually incorrect, belied by the plain language of the Hospital Cooperation Act and should be rejected.

b. Less Restrictive Alternatives

Staff characterize as "similar" the concept of "merger-specific" efficiencies under the Merger Guidelines and that of section 68-11-1303(e)(3)(D) of the Hospital Cooperation Act. (staff comments at 25) This is not correct. Under this section, the Department is required to evaluate, among many other factors, the availability of alternative 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. The two principles are decidedly different.[13] The federal antitrust agencies exclude from the competitive analysis any efficiency that is not merger-specific.[14] The Department, on the other hand, is tasked with evaluating the availability of less restrictive alternatives that would achieve the same benefits, but only as one factor out of many in its overall balancing of advantages and disadvantages. The statute requires the Department to consider benefits even if those benefits are also available in an

[12]Tenn. Code Ann. § 68-11-1303(a).

[13]Tenn. Code Ann. § 68-11-1303(e)(1).

[14]MERGER GUIDELINES at 30 ("The Agencies credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. These are termed merger-specific efficiencies.")

alternative arrangement that is less restrictive to competition. Staff do not mention this important distinction.

Staff insist that "most of the benefits of the merger could be achieved through alternatives" to a merger between Mountain States and Wellmont, such as "joint ventures and other forms of collaboration" between them. (*Id.* at 25) Staff respond that the FTC has issued "extensive guidance" on how health care providers can collaborate without violating the federal antitrust laws. The only three examples they cite for such guidance – on price and cost information exchanges, joint purchasing arrangements and physician network joint ventures – are partially or wholly inapplicable as factors driving the efficiency potential of the Mountain States-Wellmont Cooperative Agreement. (*Id.* at 26 n.95) Staff do not address, for example, the elimination of unnecessary and costly duplication (including clinical realignment and integration), from which substantial savings will be achieved through the merger. Collaboration in that regard would face significant federal antitrust roadblocks if the Parties remained competitors. The FTC knows this:

> "Most mergers completely end competition between the merging parties in the relevant market(s). By contrast, most competitor collaborations preserve some form of competition among the participants. This remaining competition may reduce competitive concerns, *but also may raise questions about whether participants have agreed to anticompetitive restraints on the remaining competition* (emphasis added). Mergers are designed to be permanent, *while competitor collaborations are more typically of limited duration* (emphasis added). Thus, participants in a collaboration typically remain potential competitors, even if they are not actual competitors for certain purposes (e.g., R&D) during the collaboration. The potential for future competition between participants in a collaboration requires antitrust scrutiny different from that required for mergers."[15]

Notably, staff's submission runs 72 pages (not counting appendices) and contains 298 footnotes, but staff do not identify a single hospital joint venture or collaboration short of merger anywhere in the country that involves the efficiencies potential provided by the Parties' Application that might serve to show that its arguments are something other than theoretical and implausible. Staff have provided literally no evidence of any alternative arrangement that would generate similar benefits as those proposed by the merging Parties. Specifically, staff fail to note that the proposed merger involves an integrated delivery system, which is fundamentally different from loose affiliations or joint ventures in its nature and effects.[16] Absent this evidence,

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[15]U.S. DEP'T OF JUSTICE AND FED. TRADE COMM., ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS at 5 (April 2000) [hereinafter COMPETITOR COLLABORATION GUIDELINES] (emphasis added), *available at* https://www.ftc.gov/system/files/documents/public_statements/300481/000407ftcdojguidelines.pdf

[16]As we discuss elsewhere, there are substantial benefits from integrated delivery networks or systems such as that proposed by the Parties; these benefits are not accounted for in the Staff analysis, which focuses on narrower traditional merger effects. For example, a Kaiser Permanente study notes the benefits of moving from independent and fragmented systems to integrated delivery systems: "Key elements of the health care delivery enterprise — physicians, hospitals, pharmacies, laboratories, and so on — are neither purposefully organized to act collaboratively across disciplines and settings nor signaled to do so by market forces. A growing body of evidence suggests that this lack of systemness contributes to documented shortfalls in quality and efficiency." (KAISER PERMANENTE INSTITUTE FOR HEALTH POLICY, *Improving Health Care Quality Through 'Systemness'*, Policy Brief (Jan. 2008)). Enthoven and Tollen address shortfalls of the current system:

mere theory cannot be considered evidentiary for purposes of consideration of this Application. This is one area where staff ignore the Merger Guidelines, which state: "Only alternatives that are practical in the business situation faced by the merging firms are considered in making this determination. The Agencies do not insist upon a less restrictive alternative that is merely theoretical."[17]

Staff contend there are "doubts" based on alleged culture differences between the Parties that the merger will succeed so as to allow the New Health System to achieve their projected efficiencies. (comments at 33) Elsewhere, staff describe the Parties as "fierce competitors." (*Id*. at 12) Staff's apparent logic is that a less restrictive alternative to achieve efficiencies on the scale projected by the Parties would more likely occur if Mountain States and Wellmont remain as "fierce" rivals while also attempting to collaborate in limited ventures – each of which would carry a substantial risk of allegations of spillover into anticompetitive restraints – than if they become a unified integrated entity, governed by a unified board, subject to public scrutiny and working under active state supervision to execute the detailed plan outlined in the Application. This is not only theoretical, it is irrational. The suggestion that the Parties remain "fierce" competitors while they attempt to collaborate to achieve synergies that staff cannot identify or quantify, and for which they have provided no examples, is fantasy and speaks to why alternative arrangements will not achieve similar benefits as those proposed by the Parties. Certainly, if staff are arguing that alternatives exist which would yield similar benefits, staff could at least provide a sound example. They have not.

The Parties have pointed out that denial of their Application would present strong potential for one or both Parties to be acquired by an out-of-market health system. FTC Chairwoman Ramirez has acknowledged growing concern that out-of-market transactions may also lead to higher prices.[18] An out-of-market acquisition also has substantially lower potential for realignment and cost savings in traditional efficiencies as well as in important health and other medical expenses.[19] Consequently, there is a significantly higher risk that prices for hospital services in Northeast Tennessee and Southwest Virginia will be higher if the COPA is denied than if it is granted. Under a COPA, the merged system will be subject to pricing caps that will keep pricing increases at a rate below the Consumer Price Index for Hospitals as reported by the United States Bureau of Labor Statistics – the most reliable indicator of resource consumption costs for hospitals and one of the best tools for predicting pricing for the

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"Many stakeholders agree that the current model of U.S. health care competition is not working…Instead, we need markets that encourage *integrated delivery systems*, with incentives for teams of professionals to provide coordinated, efficient, evidence-based care, supported by state-of-the-art information technology" (emphasis added). They go on to note that integrated delivery systems have the "ability to drive efficiency improvement and cost containment on a large scale." Alain C. Entoven & Laura A. Tollen, *Competition in health care: it takes systems to pursue quality and efficiency*, HEALTH AFFAIRS 24 (Sept. 2005), *available at* http://content.healthaffairs.org/content/early/2005/09/07/hlthaff.w5.420/suppl/DC1 Additionally, there is evidence supporting an association between integrated delivery systems and improved quality. *See* Hwang, et. al, *Effects of integrated delivery system on cost and quality,* 19 AMERICAN JOURNAL OF MANAGED CARE 5, 175-84 (2013).

[17]MERGER GUIDELINES at 30

[18]*See* U.S. DEP'T OF JUSTICE AND FED. TRADE COMM., *Workshop Transcript: Examining Healthcare Competition* (February 24, 2015), *available at*: https://www.ftc.gov/system/files/documents/public_events/618591/transcript-day1.pdf.

[19]We note that this is recognized in the economics literature cited by the FTC and in other submissions. *See, e.g*., David Dranove and Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22(6) J. OF HEALTH ECONOMICS, 983-997 (2003).

purchasers. Absent a COPA, however, there would be no antitrust impediment to an acquisition of Wellmont or Mountain States by a non-competitor, no Cooperative Agreement, and therefore no legal basis for rate regulation.

Staff respond that the literature "does not show that acquisitions by out-of-market health systems results in the same or greater price effects than a merger to near monopoly in a local health care market." (staff comments at 27) The Parties never claimed differently, although this argument misses the mark. The point is that an out-of-market merger raises a tangible risk of higher prices and the Cooperative Agreement governed by a COPA does not, because the latter is subject to price regulation and the former is not.[20] As addressed more fully below, there is evidence that a *regulated* merger said to be a "near monopoly" has the potential to result in lower costs and gross pricing than non-regulated mergers or out-of-market acquisitions.[21] Further, according to a 2011 report made to the North Carolina House Select Committee on the Certificate of Need Process and Related Hospital issues, Mission Health, a "near monopoly" created by a COPA, maintained pricing which was "well within the mainstream of hospital pricing" and costs that were "well within the median of current COPA peer group." According to this presentation, Mission Health's pricing is below comparison hospitals, and Mission Health is a "leader in health care quality and efficiency."[22] In addition to the potential pricing benefits provided through the proposed cooperative agreement, the proposed agreement, governed by a COPA provides opportunities for substantial community health benefits not achievable by an acquisition of either Party by an out-of-market health system.

3. West Virginia Recently Rejected The Same Staff Arguments

The Parties acknowledge that every proposed hospital merger – whether it is assessed under traditional antitrust law or a cooperative agreement under a law like the Hospital Cooperation Act – presents its own unique set of facts and leads to a balancing of potential benefits and disadvantages that is unique to its own circumstances. Nonetheless, and in full recognition of this principle, the Parties submit that it is instructive to review the recent detailed and carefully reasoned decision of the West Virginia Health Care Department ("WVHCA") in approving a cooperative agreement between two West Virginia hospitals that met virtually the identical policy-based opposition from staff that is present in this record.[23]

WVHCA approved that cooperative agreement pursuant to a recently enacted West Virginia cooperative agreement statute, which codifies immunity from the federal and state antitrust laws for qualified hospital mergers and includes provisions for active state supervision

[20]Moreover, staff appears to assume that a merger with an out-of-market firm that may not be able to accomplish either the same efficiencies or improvements, or continued competition between Wellmont and MSHA would keep costs and prices at current levels. This assumption has not been demonstrated, and many factors addressed in the Application about market conditions, costs of duplication and likely declines in inpatient utilization at hospitals in the area suggest upward pressures on costs.

[21]According to public data provided by the State of North Carolina, the Mission Health System has demonstrated, for every year measured, case mix adjusted net revenue per adjusted admission, and case mix adjusted costs per adjusted admission are lower than all peer hospitals in the state.

[22]*See* Thomas McCarthy, *The Mission Health System COPA*, Presentation to the North Carolina House Select Committee on the Certificate of Need Process and Related Hospital Issues (Oct. 20, 2011).

[23]In Re: Cabell Huntington Hospital, Inc., Cooperative Agreement No. 16-2/3-001 (W. Va. June 22, 2016).

by WVHCA. The West Virginia statute requires WVHCA to weigh the advantages and disadvantages of a proposed cooperative agreement (under a preponderance standard) by taking into consideration many of the same factors that are set forth in the Tennessee statute.[24]

WVHCA rejected staff's arguments in opposition to the hospitals' application, including staff's attempt to apply a traditional antitrust/Merger Guidelines analytical framework to the cooperative agreement. WVHCA decided that "this is not a federal antitrust case" and that the West Virginia Legislature "specifically provided an exemption from state and federal antitrust laws for any actions of hospitals and health care providers under the Department's jurisdiction when made in compliance with orders, directives, rules, approvals or regulations issued or promulgated by the board," citing W.Va. Code 16-29B-26. (W. Va. Decision at 35) According to the WVHCA, West Virginia sets forth a different standard for approval from that advocated by staff, and the WVHCA will not apply a standard reserved for an antitrust action to a state law matter. (*Id.* at 36)

Many of the WVHCA holdings with respect to staff's specific arguments are strikingly pertinent here:

- Due to increased combined volume, the merged entities have greater ability to offer sub-specialty care, because critical mass for tertiary sub-specialist level work is much more achievable and the hospitals separately lack sufficient volume to recruit physician specialists for such programs as highly complex orthopedic and cancer surgery and a kidney transplant program. (*Id.* at 10, 28-29)
- In response to staff criticism that commitments and benefits were not merger specific, the WVHCA held that the proposed cooperative agreement involves issues of health care law under the West Virginia statute, not a federal antitrust matter. (*Id.* at 13)
- With respect to improved quality, the WVHCA noted that unification of protocols and practice will bring efficiency and improve quality of care, including for example, using evidence-based medicine to have a sepsis protocol in both hospitals. (*Id.* at 30, 32)
- The hospitals have made enforceable commitments to establish a fully integrated and interactive medical record system at both hospitals, so that a patient's encounters will be more readily available. The WVHCA emphasized the importance of a modern database and fully integrated and interoperable medical records system so that patient encounters at each hospital can be readily available to treating physicians at either hospital in real time, which is particularly important for hospitals located in close proximity to each other where patients may seek services at one hospital one day and at another a different day. (*Id.* at 30)
- According to the WVHCA: "No population health strategy can succeed without robust integrated data analytics for the entire population across the entire continuum of care." (*Id.* at 30)
- The WVHCA specifically credited "numerous articles" from members of the academic community and governing specialty organizations that support the

[24]Tenn. Code Ann. § 68-11-1303(e).

proposition that high volume is associated with better outcomes across a wide range of procedures and conditions. (*Id.* at 31)

- The WVHCA credited the efficiency estimates of the hospitals, rejecting the contention that the efficiencies must be merger specific, stating that it will not apply a standard reserved for an antitrust action to a state law matter. (*Id.* at 36)
- The WVHCA specifically noted the continued significant support by the hospitals for medical education in the region and that this level of support could be drastically reduced or eliminated if one of the hospitals was acquired by another hospital system. While objectors argued that other hospitals may be willing to make similar commitments, "[b]ased upon the importance of these programs to service area residents, the Department is unwilling to jeopardize these programs." (*Id.* at 40, 43-45)
- The WVHCA was particularly concerned about jeopardizing these medical education programs in an area in which risk factors for cardiology services are so high, such as obesity and smoking. (*Id.* at 40) In this regard, the WVHCA noted the hospitals' support for education of primary care physicians who will serve in rural communities, commitments which are too critical to the community to jeopardize based on speculation. (*Id.* at 17) In primary care and in specialty areas, most residents end up practicing within 50 miles of the training program. (*Id.* at 18)
- The hospitals argued that a single hospital system can better analyze community needs and formulate and implement education and other programs to engage the community. The WVHCA rejected staff's contentions regarding lack of specific goals or timeframe, noting that the hospitals had committed to terms for developing goals for population health improvement for the next ten years and that a merger of the two hospitals would enhance quality because increased volume in specific areas has shown to lead to better outcomes. (*Id.* at 47-49)
- While staff argued that the hospitals should be more specific about the duplication to be avoided, the WVHCA stated that a merged system will clearly not be purchasing duplicative equipment. (*Id.* at 51-54)
- The WVHCA specifically focused on the fact that the population to be served has more significant health challenges than the United States generally. Specifically, the higher rates of many chronic conditions, such as obesity, diabetes, heart disease and cancer and behavioral issues 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 WVHCA concluded that combining the two hospitals "aligned with other providers along the care continuum as well as stakeholders in the community creates a unique opportunity to marshal 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." (*Id.* at 21) In this regard, the WVHCA specifically noted the philosophy and culture of the governing boards, composed of local community and consumer representatives. (*Id.* at 95)
- Constraints on increases in total costs of care – While staff argued that the hospital's rate commitments, including a benchmark rate, were vague, the WVHCA rejected those arguments as speculative. (*Id.* at 57)

In conclusion, the WVHCA stated with respect to the cooperative agreement:

> It creates an opportunity for savings which are specific to this transaction and could not be achieved by another purchaser of [Saint Mary's Medical Center (SMMC)]. It enables a fully integrated and interactive medical records system which will have far more importance for hospitals in close proximity to each other than could be achieved were SMMC to be acquired by a remotely located purchaser. It permits system wide coordination of community health initiatives. It assures local control of SMMC and continued support by SMMC for the Joan C. Edwards School of Medicine. It makes possible the implementation of common protocols and establishment of the centers of excellence through a single hospital system serving the region. It enhances the ability of the hospitals to recruit highly trained physicians. It makes possible the expansion of services locally so that the requirement for burdensome patient travel to other areas will be reduced.
>
> [The acquiring hospital] notes that it is important to remember that [the acquired hospital] will be sold. The benefits listed above as well as many other benefits from the transaction could be lost to the community if [the latter hospital] is sold to another purchaser. (*Id.* at 100)

The Parties respectfully submit that WVHCA's rationale for rejecting staff's antitrust law arguments concerning the application for a cooperative agreement in that state has equal force in the matter now before the Tennessee Department of Health. Accordingly, staff's comments to the Parties' Cooperative Agreement should be rejected here as well.

C. Staff's Comments On The Statutory Factors Lack Merit

In their comments, staff address the individual statutory factors that the Department must evaluate when assessing the potential benefits and disadvantages resulting from the merger. Staff assess these factors under a federal antitrust law framework and do not identify a single aspect of the merger that they view to be a benefit. Staff's comments contain irrelevant antitrust arguments and unfounded criticisms of the Parties' substantial commitments to the region and their demonstration of substantial benefits resulting from the merger.

The Parties respond below to staff's specific comments, but first address a few points in the FTC's Executive Summary. Most of the claims in the Executive Summary are raised again in later sections of staff's submission, and the Parties respond to them elsewhere below.

Staff state that they recognize the challenges facing many states regarding unmet health care needs in rural communities and the regulatory and financial pressures that providers face in delivering health care services in those areas. (staff comments at 1) But nowhere in their submission do they acknowledge, let alone address, the specific, pervasive health problems confronting patients in Northeast Tennessee that the Parties have detailed in their Application and subsequent submissions to the Department (briefly mentioned above). Staff ignore the strained economic conditions that have led to the need for each system to absorb more than $19 million in losses annually to ensure inpatient services continue to remain available in their

respective rural service areas and the high number of rural hospital closures across the country. Staff ignore that the projected decline in inpatient utilization in the region, when combined with flat or negative population trends, leads to additional losses as both Wellmont and Mountain States must absorb an expected loss of between 13,000 and 30,000 discharges annually.[25] These are examples of facts that underlie Tennessee's cooperative agreement policy and illustrate the rationale for the Parties' Application, but staff do not acknowledge or comment on them.

In fact, in the face of these distressed health and economic conditions, staff state without substantiation that "[c]ompetition between Mountain States and Wellmont *greatly benefits* area employers and residents."[26] (*Id.* at 2; emphasis added) Obviously, the Legislature has concluded that competition has not achieved the needed benefits throughout Tennessee, or at least that an active regulatory program has the potential to outperform competition. The effects of a competition policy in Tennessee include, among other things, that Tennessee has seen the second highest number of hospital closures since 2010, several rural hospitals in the region operating with substantial losses, a reduction in the number of funded residencies in the region supported by the two major health systems, a shortage of certain specialties in pediatrics and other specialties such as endocrinology in a region suffering from a high rate of diabetes, a lack of residential addiction recovery services in a region suffering among the highest rates of opioid addiction and deaths from addiction, and a lack of community based mental health services sufficient to serve the burgeoning needs in the region.[27] While competition has not met these needs, on the other hand, there is an abundance of certain specialties which generate revenue-producing hospital admissions, and two Level 1 Trauma Centers within a 20 minute drive and no pediatric trauma services.[28] The mismatch of resources with need is clear. These conditions are reflected in the overwhelming community support for the merger discussed above.

Staff express concern that a COPA for the Parties' Cooperative Agreement "would undermine" the State's goals (*id.* at 2) but do not answer, for example, where the region will find financial resources of the magnitude of the Parties' commitments for significant incremental investment in population health, addiction recovery and treatment, expansion of specialty services and the other region goals if the State denies the Parties' Application. In fact, since the

[25]With approximately 126 discharges per 1,000 population currently, the region runs substantially higher than national use rates of between 90-110 admissions per 1,000. It is projected that discharges in the relevant market will decline to somewhere in this range in the next 5 years. The combined system generates approximately 100,000 discharges. Based on this data, the decline in discharges can be expected to be in the range of 13,000 and 30,000.

[26]See Section I. above for comments in support of the merger from area employers.

[27]*See* Ayla Ellison, *A state-by-state breakdown of 80 rural hospital closures*, BECKER'S HOSPITAL REVIEW (Dec. 13, 2016. McNairy Regional Hospital in Selmer, Tenn., part of Knoxville, Tenn.-based Tennova Healthcare, closed May 18. The hospital's admissions had dropped nearly 70 percent between 2010 and 2015, and ER visits had also plummeted. *See* BECKER'S HOSPITAL CFO (June 2016); *see also* WATE (June 17, 2016) (Scott County reacts to Pioneer Community Hospital closing), *available at* http://wate.com/2016/06/17/scott-county-reacts-to-pioneer-community-hospital-closing/ June 17. Since 2010, there have been 8 rural hospital closures in Tennessee, four of which occurred in 2015 and 2016. *See* THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH AT THE UNIVERSITY OF NORTH CAROLINA, *80 Rural Hospital Closures: January 2010 – Present* (as of December 17, 2016) ("80 Rural Hospital Closures: January 2010 – Present") (Fourteen rural hospitals have closed since the Application was filed in February, 2016, including two rural hospitals in Tennessee.), *available at* https://www.shepscenter.unc. edu/programs-projects/ruralhealth/rural-hospital-closures/.

[28]Tennessee has 6 licensed Level 1 Trauma Centers. In each region outside the Tri-Cities, there exists one Level 1 Trauma Center and one Pediatric Trauma Center. In the Tri-Cities, there are two Level 1 Trauma Centers, one Level 2 Trauma Center, and no Pediatric Trauma Centers, leaving the Tri Cities as the only region of the state without a licensed Pediatric Trauma Center.

State has no alternative funding source for addressing these priorities, staff ignore completely the value of the resources that are being made available as a result of the Cooperative Agreement. These funds are available only through synergies generated by the merger under the Cooperative Agreement. The commitments proposed by the Parties not only do not "undermine" the State's goals, the evidence shows they are aligned with the State's goals as enumerated in the State Health Plan.

1. Staff's Market Share And Concentration Analyses Are Not Informative

In section IV, staff state that the merger's benefits are unlikely to outweigh the disadvantages that would result from the loss of competition between the Parties (comments at 8), and in section IV.A that the merger "would likely lead to increased prices and reduced quality and availability of health care services in Southwest Virginia and Northeast Tennessee." (*Id.* at 9) These statements are speculative and staff provide no evidence to support them. Staff discuss market shares and market concentration and the inferences to be drawn from structural statistics in traditional merger analysis. (*Id*. at 9-15) This discussion ignores that the merged health system will be subject to a rate cap commitment that will prevent anticompetitive prices and to commitments to improve quality and expand access that are based on actions that the Parties will be undertaking as part of the merger. Staff do not explain how the market power they predict based on the share/concentration statistics will be exercised under the watchful eye and active supervision Department officials and sophisticated bargaining abilities of commercial health plans.

Staff evaluated the Hospital Cooperation Act's statutory factors "in conjunction with [their] standard analysis under the Merger Guidelines." (*Id.* at 8). In other words, they conducted an antitrust law analysis that, as discussed above, is inapposite to a cooperative agreement analysis under the Hospital Cooperation Act. Staff conclude that Mountain States and Wellmont are competitors and the two largest health systems in their 21-county geographic service area in Tennessee and Virginia. This is not in dispute. Staff's inpatient market shares and concentration statistics merely inform the Department that in staff's view the merger may be anticompetitive. Staff's discussion in this section does not address whether the benefits from the merger outweigh its disadvantages as required under the Hospital Cooperation Act.[29]

Staff notes the few physician specialties where the combined Mountain States and Wellmont share of physicians would exceed 50%. These specialties include cardiovascular services, urgent care services, pulmonology services, and oncology & hematology services. Staff notes that the shares reported in the original COPA application in February differ from those in supplemental update, and they claim the Parties did not provide a rationale for any changes. They imply that changes may understate actual shares by newly including mid-level practitioners or changing categories.[30] Staff has once again failed to read the actual request from the Tennessee Department of Health and the response provided by the Parties.

[29]Moreover, staff assumes rather than demonstrates the benefits and effects of continued competition in this marketplace.

[30]Staff comments at 17-18 ("Mountain States and Wellmont have since submitted a revised table showing lower combined shares in these and other physician specialties, but they did not provide any underlying data that might explain the discrepancy between the two sets of shares. The revised table may understate the applicants' combined physician shares by including mid-level health care practitioners, such as physician assistants and nurse practitioners, as well as by consolidating physician

The Tennessee Department of Health requested in its April 22nd correspondence that the Parties:

> Revise the lists of services and products in Application Section 11, Exhibit 6, and Addendum #1 Section 3 to reflect the following changes:
>
> **i. Provide information on the structure of physician practices to calculate the appropriate market share.[31]**

The Parties addressed this request in their response dated July 25, 2016.[32] As noted in their response, the supplemental table was updated to take into account data on employment and affiliation from the four months since the Application was filed (February 16, 2016). It also included efforts by the Parties both to update the underlying categories of specialties to provide greater uniformity and simplicity in the categories in order to create clear, consistent categories for comparability. Specifically, the efforts resulted in categories that were more likely, rather than less likely, to result in "overlaps." This is confirmed by the fact that the overall share of physicians that are independent remained roughly the same.

Staff expresses concern that physician shares with inclusion of mid-level health care practitioners may dilute or lower shares of the Parties' employed or affiliated physicians.[33] In fact, the share tables provided in the original Application also contained mid-level practitioners, and as such, this was not a change in the updated tables. The inclusion of mid-level practitioners was a conservative approach and the exclusion of mid-level practitioners results in lower shares for physicians in the aggregate. If you look at physician numbers (not total provider numbers), Mountain States and Wellmont have a comparable, if not lower share, than when including mid-level practitioners.

In this section and throughout their submission, staff repeatedly claim support from economist research papers that staff say reflect "a large and growing body of empirical research finding that mergers between close competitors in consolidated health care provider markets are likely to result in substantial consumer harm, without offsetting improvements in quality." (comments at 9) For example, notes 29, 30 and 31 on page nine of the staff submission all cite to one or more such papers co-authored by economist Martin Gaynor, as do footnotes 4, 19, 24, 31, 46 and 54 – combining for more than a dozen references. Not one of the Gaynor or other papers that staff cite analyzes the consumer effects of a merger that was subject to regulation and active supervision under a statutory framework like the Hospital Cooperation Act. Without such analysis, staff have no foundation in stating that a merger under state supervision and in compliance with the Hospital Cooperation Act will cause consumer harm or result in poor

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specialty categories that were reported separately in the initial application.").

[31] *See* Letter from the Department to Bart Hove, President and CEO of Wellmont, and Alan Levine, President and CEO of Mountain States (April 22, 2016), *available at* https://www.tn.gov/assets/entities/health/attachments/TDH_Request_for_Information-2_4.22.16.pdf

[32] *See Responses to Questions Submitted April 22, 2016 by Tennessee Department of Health in Connection with Application for Certificate of Public Advantage,* at 10-11 (July 13, 2016), *available at* http://tn.gov/assets/entities/health/attachments/WHS-MSHA_April_22,_2016_DOH_Response_1.pdf.

[33] Staff comments at 17-18.

quality. To the contrary, the Parties have provided evidence that a merger under state supervision and in compliance with the State's law can lead to pricing which is lower than the peer hospitals while emphasizing high quality and efficiency.

Staff do not disclose this important fact about the literature it advances or explain how this literature could inform the Department in its decision-making process. All this touted research purports to show is that hospital mergers between close competitors in concentrated *unregulated markets* on average result in anticompetitive effects. Staff ignore the obvious wide gap that separates the ability of an unregulated firm with market power, compared to a firm with market power but also subject to regulation and active state supervision, to exercise that power. The gap is even wider in the hospital setting, because hospitals contract with highly sophisticated managed care organizations that not only have the expertise timely to spot violations of cooperative agreement commitments, but also the infrastructure and incentive to report violations to state supervisors on a timely basis.

Professor Gaynor and other academics submitted a memorandum to Commissioner Dreyzehner in which they "urge the Department of Health to reject" the Parties' Application. The memorandum argues that hospital mergers between close competitors in highly concentrated markets are bad for consumers, and cites to "an extensive body of economic literature" that supports their view.[34] Just like staff, the professors do not mention that the literature they advance lacks any analysis of a regulated health system that is under active state supervision and subject to strict commitments in a cooperative agreement. The Department should accord no weight to these studies.[35]

Finally, neither staff nor the Academics acknowledge that mergers regulated under state cooperative agreement statutes have resulted in lower costs, apparent lower pricing and in at least one case, have led to the hospital market being recognized as having among the highest value hospital systems in the nation.[36]

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[34]Academic comments at 1. The authors identify five papers for this "extensive body" of literature, including one from Professor Gaynor.

[35]Staff's irrelevant policy desire for competition actually is understated compared to Professor Gaynor's. Regarding West Virginia's law and WVHCA's approval earlier this year of a cooperative agreement for two local hospitals, Professor Gaynor attacked the policy as well as the public officials who established it. He said on Twitter: "Monopoly wins, patients lose. WV state government fails its citizens;" and "Ugh, WV legislators, governor should be ashamed of themselves (if they had any shame)." See Exhibit III.A. Professor Gaynor points to no empirical analysis of a hospital merger under a cooperative agreement, but nonetheless sees fit publicly to express apparent contempt not just for the sovereign policy but also for the motives and competence of the policy-makers. This undermines his credibility in opining on the objective merits of the Parties' Application.

[36]The Urban Institute has published a report which cites national experts referring to Mission Health in Asheville, North Carolina ("Mission"), as one of the highest value health systems in the nation. *See* Randall R. Bovbjerg & Robert A. Berenson, *Certificates of Public Advantage, Can they Address Provider Market Power?*, URBAN INSTITUTE, at VI (February 2015), *available at* http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf. Further, according to the annual Independent Accountants' Report on Applying Agreed-Upon Procedures, a report to North Carolina's Department of Health Services Regulation by Dixon Hughes Goodman, the data released by the State of North Carolina demonstrates that for each of the 9 years the report is publicly available from 2007-2014, Mission demonstrated lower operating costs per adjusted admission and lower revenue per adjusted admission (on a case mix adjusted basis) than its peer hospitals in North Carolina. Neither staff nor the Academics credibly refute these facts. Buncombe County, North Carolina, where Mission Health resides, has a population of approximately 250,000. The population of Washington County, TN, and Sullivan County, TN, which is where the Parties' hospitals reside which generate 60 percent of the admissions of the combined system, has a combined population of approximately 258,000.

2. Post-Merger Rate-Setting And Contract Negotiations With Insurers Will Be Transparent and Verifiable

In their comments in section IV.A.2 and A.3, staff contend, respectively, that the merger "would greatly enhance the hospital's bargaining power" over hospital rates and over certain physician specialty rates, "which would lead to substantially higher prices for consumers." (*Id.* at 21) Staff, cross-referencing to Section VI.A of their submission, state that the price commitments made by the Parties to the Department "are unlikely to mitigate this harm." (*Id.* at 21) They contend that the Parties' commitments lack transparency and are subject to the Parties' manipulation. This reflects a fundamental misinterpretation of the facts. The Parties' proposed commitments would create a substantial constraint on rates that keeps them at levels commensurate with a competitively bargained contract. The process is transparent and readily subject to verification by commercial payers and the Department.

Staff contend that the timing of certain of the Parties' rate-related commitments is unclear. (comments at 57-58). The Parties have committed to reduce existing commercial contracting for fixed rate increases by 50 percent for one year ("Rate Reduction Commitment") and to a rate cap applicable to certain payers ("Rate Cap Commitment"). With respect to the Rate Reduction Commitment, staff point to a language difference between the Parties' submission to the Southwest Virginia Health Authority ("SVHA") in response to staff's comments to that agency ("Parties' Virginia Response")[37] and the Parties' subsequent revised commitments with the SVHA ("Revised Commitments").[38] (*Id.*) Staff also identify a language inconsistency on this subject within the Revised Commitments themselves. (*Id.* at 58) To clarify, the timing for the Rate Reduction Commitment to which the Parties and SVHA agreed is correctly described in the commitment's description: "For all Principal Payers, the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System."[39] We note that staff never acknowledge that this commitment results in an immediate reduction relative to pre-merger negotiated rates for relevant Payers, which provides them resources to invest back in consumers or programs to benefit this area, or more directly, to reductions in costs for purchasers which are self-insured.

Staff also contend that timing of the Rate Cap Commitment is unclear (staff comments at 58), but on this staff are incorrect. The Parties' Virginia Response states that the Rate Cap Commitment would be effective "immediately upon consummation of the merger."[40] The Revised Commitments very similarly state that the Rate Cap Commitment would be "effective

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There are distinct similarities between the North Carolina market served by Mission and the Tennessee market served by the Parties. Yet, staff and the Academics ignore these facts.

[37] *Response by Applicants to Federal Trade Commission Staff Submission on September 30, 2016,* at 15-16 (October 14, 2016), [hereinafter "Sept. 30 Response"], *available at* https://swvahealthauthority.files.wordpress.com/2016/09/ response-to-ftc-comments-submitted-to-swvha.pdf.

[38] *Revised Commitments*, SOUTHWEST VIRGINIA HEALTH AUTHORITY (Oct. 12, 2016) [hereinafter "Revised Commitments"] available at https://swvahealthauthority.net/commitments/.

[39] *Revised Commitments.* The Parties have recommended that the same revision be incorporated into the Tennessee COPA.

[40] *See Sept. 30 Response* at 15.

on the closing date of the merger."[41] Contrary to staff's assertion, language in the "Timing" section of the Revised Commitments that the commitment applies to "subsequent contract years" is not inconsistent with the Parties' stated commitment that the proposed rate cap would apply upon closing of the merger. Staff's other criticisms of the rate commitments do not have merit.

a. Concerns About The Proposed Rate Cap Mechanisms Are Unfounded

Staff contend that the proposed rate cap will result in rate growth trends that will exceed those likely to occur at Wellmont and Mountain States if the transaction does not occur. The concerns expressed focus on either (1) the price index used to set the rate cap, (2) the concept that the rate cap will act as a rate floor, or (3) that continued competition would have resulted in substantially different pricing.

i. The Price Index Is Appropriate For The Rate Cap

Staff charges that use of the medical CPI index as the basis for comparison with actual rate growth may result in higher rates of increase in rate growth, due to the index's components or the fact it is a national (or regional) average across all hospitals and may not reflect local cost trends. (staff comments at 57) This argument lacks merit.

As a threshold matter, when Tennessee enacted the Hospital Cooperation Act and its pathway for qualified health care mergers under a program that replaces competition with regulation and active State supervision, it is fundamental that the Legislature also contemplated that a mechanism be established to protect consumers from unreasonable pricing. An argument that competition is a better means for ensuring fair prices is not meaningful, because the Legislature expressly contemplated that competition would be supplanted if the COPA for the Cooperative Agreement is approved. The only issue before the Department in this respect, therefore, is whether the rate protection mechanism under consideration will work effectively and in a consistent way with the broader Tennessee policy principles embodied in the Hospital Cooperation Act.

The rate caps are intended to emulate the beneficial effects of competition. The rate caps provide the mechanism by which the Parties and Department can be assured that any post-merger price increase is both reasonable and a reasonable approximation of what would likely occur with competition. This mechanism involves two parts – an actual rate increase and a measure of "competitive" or "marketplace" rate increases. The rate regulation methodology needs both to be sufficiently flexible to adapt to changing circumstances and to provide a sound means for the State reliably to test and evaluate actual rates of price increases. States and private entities in their contracts often include various measures of medical expense, cost, or some measure of price as a pre-determined reliable measure of marketplace rates or rate increases and also use similar index or measures to compare actual rate increases to some metric (*e.g.*, rate of GDP growth or an index).

The goal of rate caps is to regulate the rate of growth in prices post-merger consistent with a competitive environment, not to replicate precisely the pricing growth that Wellmont and

[41] *See Revised Commitments* at 2.

MSHA each would have negotiated in future years. Such rate negotiation outcomes cannot be predicted with precision, and there is no basis for concluding that recent actual price terms negotiated with payers would have been replicated across all new and future contracts.[42] For example, absent the transaction, both Wellmont and MSHA might have faced pressures to increase rates to commercial payers to cover costs associated with spreading smaller inpatient volumes across higher fixed cost facilities with excess capacity and to achieve sufficient revenues to sustain operations across facilities.[43]

Any concerns that use of the index will result in substantial deviations from the "competitive price" or in substantial rate inflation are immediately undermined by referring to the index itself. Examination of recent CPI trends reveals that the rates of increase are low, reflect common cost pressures across hospitals, and are very consistent and reasonable rates of change for application to all future contracts. They emulate, in other words, likely competitive trends. Moreover, rate caps are intended to be caps and not precise point estimates. Thus, it is irrelevant whether in any one year or one contract the Parties reach the cap – so long as the cap itself represents a reasonable level.[44]

Concerns about the specifics of the CPI measure are unfounded, particularly since the CPI measure is determined by the United States Department of Labor, Bureau of Labor Statistics. It is a common and reliable index. No commenter has suggested a superior alternative to CPI measures. Economists considering the Mission Health index suggested that regional and other indexes work well for estimating and testing price changes, which is what is at issue here.

ii. The Proposed Rate Cap Is Not A Rate Floor

Staff contend that the proposed rate cap may operate as a rate floor. (staff comments at 58) This is speculative, unsupported by the evidence and ignores the realities of commercial negotiations. Information on the CPI is readily available to everyone, as will be the rate cap. Both insurers and the New Health System will come to negotiations with informed positions as to the likely value of the CPI based on most recent year's data and information readily available from public sources.

The presence of a known rate cap with a relatively small range of values sets an outside value for the starting point of negotiations from the New Health System perspective that is likely to be lower – and perhaps by a significant amount – than current starting points for negotiations. Parties will be negotiating from a narrow range. Given recent changes in CPI, the rate cap is likely to be in the 2-4 percent range in upcoming years, which reflects a very modest rate of

[42]It is common to see newly negotiated contracts have somewhat higher rates of increase, particularly where the prior contract had a longer term, due to changes in underlying costs and other factors. *See* Appendix for further discussion.

[43]Commenters fail to account for the fact that competition can lead to greater capacity than efficient or optimal for a marketplace. Hospitals acting independently will choose to invest in and sustain more capacity to be able to serve the marketplace; in areas such as the GSA with its largely rural population and substantial Medicare and Medicaid population and the need to have several facilities located throughout the area to serve the population, this can result in facilities that have excess capacity and may not be financially sustainable at current payment levels. For a discussion of the economics of excess capacity, see Kathleen Carey, *Stochastic Demand for Hospitals and Optimizing "Excess" Bed Capacity*, 14 J. REG. ECON. 165 (1998).

[44]Moreover, the actual rate cap represents more of a constraint and is lower due to the fact that in the first period rates will be reduced through other provisions committed to by the Parties.

change for new contracts. The rate cap is also considerably below the model-predicted (and highly unrealistic) estimate of 130 percent price increases that staff reference[45] and well below any levels that would appear likely to raise concerns about price increases. Moreover, the cap will be a cap – even if it is the floor, the floor is also the ceiling, and rate increases will be constrained to reflect measures of overall cost changes based on neutral benchmarks that in recent history have been small percentage changes. The cap provides for predictability around a relatively small range of rate changes across all contracts covered by the provision, including ones being newly negotiated from one year to the next. This provides payers, as well as self-insured employers, greater assurances about expected and future rates of change in expenditure.

iii. The Rate Cap Commitments Will Work To Protect Consumers

Staff vaguely speculate that "it is difficult, if not impossible, to foresee all of the ways" the price commitments could fail or be circumvented. (staff comments at 57) Staff misunderstand the rate cap and overall process that will occur under a Cooperative Agreement. Any attempted changes away from current customary and usual contract terms that would permit circumvention would be immediately detectable by payers and readily reported to the Department as part of the active supervision function.

The proposed rate cap approach, which includes a price cap and its application to inpatient, outpatient and physician services, is consistent with the principles espoused by two economists in North Carolina who were charged with addressing many of the same issues in the Mission Health COPA.[46] There, Drs. Capps and Vistnes recommended the form of rate cap

[45]Staff provides nothing more than diversion ratios in statements regarding alleged post-merger price increases by the New Health System. These diversion ratios are calculated based on patient choice models with significant limitations for estimating predicted price increases and which importantly do not account at all for practical realities of negotiations with major payers such as BCBS of Tennessee and Anthem, which represent predominant sources of critically needed commercial revenues. In fact, staff rely without any vetting of the reliability or accuracy on the unrealistically high price increase estimates developed by consultants hired by America's Health Insurance Plans: "Indeed, Competition Economics LLC, an economic consultant hired by America's Health Insurance Plans to analyze the proposed merger, estimated that the price increase could be as high as 130%." (staff comments at 12-13) That analysis also estimated very high diversion ratios between Mountain States and Wellmont. *See* Michael Doane & Luke Froeb, *An Economic Analysis of the Proposed Merger Between Wellmont Health System and Mountain States Health Alliance*, COMPETITION ECONOMICS LLC, at Tables 10, 12 & 13 (Oct. 29, 2015) (economic analysis funded by America's Health Insurance Plans). It is revealing of staff's adversarial approach to their comments that they refer the Department to an economic paper that predicts a potential price increase of 130 percent – an absurd conclusion on its face. The paper was published months before the Parties' Application that described the rate cap formula – a development that even further accentuates the irrelevance of that paper. Moreover, staff did not advise the Department that the authors admitted that their analysis "has its limitations" and that, concerning the models they used, "[c]ritics have noted that errors in the WTP framework include the reliability of the hospital choice model (including its strong reliance on travel time as a determinant of hospital choice) and the measurement of the relationship between WTP and hospital prices." They also admitted that "such criticisms may affect the magnitude of precise price predictions" but they stuck to their prediction of large price increase nonetheless "because this merger is so big" – a conclusion hardly grounded in robust economic analysis or thoughtful consideration of the rate cap formula. (*See id*. at 18) Issues with regard to the reliability of price prediction models are discussed in Christopher Garmon, *The Accuracy of Hospital Merger Screening Methods"* (2016) and in Bryan Keating, et. al, *Comment on Farrell, Balan, Brand and Wendling* (2011), *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets* (2012).

[46]Reports by Dr. Greg Vistnes and Dr. Cory Capps were developed as part of the review of the performance of the Mission Health COPA; additional analyses on price levels and trends were provided by Dr. Thomas McCarthy. *See* Thomas McCarthy, *The Mission Health System COPA*, Presentation to the House Select Committee on the Certificate of Need Process and Related Hospital Issues (2011); Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health System* at 32 (May 2, 2011). *A Review of the Analysis of Dr. Greg Vistnes, with Additional Recommendations for Lessening Opportunities for Regulatory Evasion by Mission Health,* at

regulation similar to what the Parties propose Tennessee and Virginia as a preferred form for price regulation in a COPA context. They determined that changes in the Mission Health form of regulation (tied to margin and cost levels) and in the services covered (which were inpatient only) would eliminate much of the perceived distortion in incentives and improve the effectiveness of regulation in that case. [47]

Dr. Capps recommended that the cost and margin cap utilized in the Mission Health COPA be replaced with a "cap on the rate at which Mission Health's pricing to commercial insurers can grow" and that the "price growth cap should be computed separately for inpatient and outpatient services."[48] Dr. Capps noted that "switching to direct price regulation . . . is a more straightforward and effective approach to achieve the State's goal of using oversight [to assure that benefits of agreements outweigh costs of reduced competition]." [49] He also proposed regulation of price levels at Mission Health using peer hospital benchmarks. (This change is not required here because the New Health System COPA will commence from current (competitive) price levels. Drs. Capps and Vistnes, in contrast, were undertaking an ex-post evaluation of pricing after the COPA was underway.)

The price cap approach that Drs. Capps and Vistnes recommended in North Carolina to address perceived incentive or compliance issues provides support for the Parties' proposed rate cap and rate regulation features insofar as: (1) regulation of the rate of increase in price growth relative to some index; and (2) application of the regulation both to inpatient and outpatient services to avoid any alleged regulatory evasion or distortion of incentives. Here, moreover, the Parties have gone further to specify the relevant index measures, to propose immediately to cut in half any fixed escalator rate in existing contracts, and to offer specific methods for how the New Health System can verify changes in price growth on existing and on new contracts with the payer and also with the regulatory Department.

iv. Rates In New Payment Model Contracts Will Be Protected

Staff (staff comments at 59) criticize the proposed rate caps as inapplicable to risk-based contracting models, including those that include quality or outcomes adjustments or shared savings/risk models. Staff's comments are not valid. There are many potential variations in the form of a "risk-based" contracting model based on the contracting parties' characteristics, such as the capabilities and objectives of the health provider and payer. Most risk-based models, including in contracts now in place with certain payers in the region, commence with fee-for-

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Section III (May 2011); Greg Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health*, at 18-19(February 10, 2011).

[47]There were differences of opinion whether Mission Health's prices and costs had increased at rates not consistent with effective rate regulation. *See, e.g.*, McCarthy at 2-4; Capps at 16. That issue is not relevant to the efficacy of the rate cap regulation proposed in the Application.

[48]Capps at 16; *A Review of the Analysis,* at 15.

[49]Capps at paragraph 25-26 (referencing Vistnes' recommendations and presenting his views); *Review of the Analysis* at 16. Dr. Capps also did not appear to believe that regulation of price levels (in addition to rates of increase) would add substantially to the "administrative burden" for the state. Both Dr. Capps and Dr. Vistnes proposed adjusting price caps to account for case mix adjustment, by using net patient revenues from total commercial insurers by total case-weighted output for inpatient services and outpatient services separately. Their proposed rate regulation would involve only a single rate of price growth rather than one for each payer.

service pricing on hospital, outpatient, and physician services as an input into the risk-based elements.

The Parties expect this approach to continue for the foreseeable future, such that a substantial volume of risk-based contracts will involve limited risk shifting and operate with pay for performance and value-based terms.[50] The price cap will thus have an immediate impact on the most relevant forms of risk-based contracting currently in place or anticipated in the near term. In fact, the price cap regulation forms a basis and a bridge for transition to future risk models, and other commitments regarding engagement with payers on quality metrics and overall transparency will provide further support. It is envisioned that the Parties will continue to work with payers on new models, and that these can be developed in a form that can be reviewed by the Department under its active supervision role to assure that overall terms are reasonable. It is important to note in this regard that the Department will have access to detailed information about the prices charged by the New Health System. Additionally, the Department retains the authority to modify the cooperative agreement as necessary to adjust to the evolution of risk-based contracting.

Staff refuse to acknowledge the immediate benefits of the rate cap and related commitments. They involve an initial substantial "rebate" to payers and ASOs, in the form of reduced inflators in existing contracts which have fixed inflators. This reflects a substantial dollar amount to the recipients that can be shared with Tennessee (and Virginia) consumers or invested in important population health or wellness initiatives specific to the population. Another key benefit is predictability and certainty about fee-for-service increases, which redounds to the benefit of both payers and employers in making their important planning and financial decisions. The competitive market absent the Cooperative Agreement could not provide that predictability or certainty in this area. The Parties' proposed form of rate cap regulation and its application across each of the major services (inpatient, outpatient, and physician services), along with the use of an external index that covers common trends in hospital costs, provide a compelling and decisive counter to speculative charges by staff and other commenters that price protection is incomplete or subject to evasion.

D. The Definition Of Commercial "Principal Payers" Is Appropriate

The Parties' proposed rate cap is limited to "Principal Payers." The Parties originally defined this term to mean "those commercial payers who provide more than 2 percent of the New Health System's total net revenue" (Application at 46) but recently proposed to the Department a revision that would include "governmental payers with negotiated rates" along with commercial payers in this definition.[51]Staff criticize the 2 percent limitation, contending that enrollees in plans offered by non-Principal Payers will have no protection in future rate negotiations, but do not propose an alternative approach. (comments at 58) The payers who fall below the 2 percent threshold have a *de minimis* presence in Northeastern Tennessee. Collectively, the approximately 200 payers in this category together account for less than 3

[50]Many of these contract terms for value-based approaches are established, and the Parties have committed to transparency and further engagement with payers on these. The Parties have every incentive to continue to align incentives across their newly integrated health care delivery system and with payers to manage risk and enhance value.

[51]Letter from C. Haltom to A. Rajaratnam (Nov. 15, 2016) (attached Commitments Chart, no. 1).

percent of the New Health System's total net revenue. From a business perspective, application of the proposed rate cap to such *de minimis* payers could risk net losses to New Health System.[52]

The Principal Payer limitation, contrary to staff accusations, also promotes administrative simplicity and enforcement. (See staff comments at 56-57) In their active supervision of the New Health System to ensure compliance with COPA requirements, Department officials will rely in part on key stakeholder input. The Principal Payer limitation focuses on those payers that are well-positioned to model the likely impact of negotiated rates based on their current use of such models in evaluating contracts. These payers will readily be able to demonstrate the Parties' compliance or report any potential violation of the rate cap commitments to the Department. Overall, changes made possible by the merger and increased transparency are likely to benefit smaller payers as well. In addition, smaller payers will be protected by their ability to raise concerns with the State.

1. Staff's Arguments About Quality And Access Are Unsupported

Staff's arguments regarding quality of care and access under the Cooperative Agreement are grounded in their irrelevant policy opinion that the Hospital Cooperation Act law is not in the best interest of Tennesseans, despite that the Legislature and Governor of Tennessee have made it state policy. They contend that "non-price dimensions of competition greatly benefit patients," that "competition between the systems" is responsible for many consumer benefits, that "competition-reducing mergers often reduce quality," and "[t]herefore" that "the proposed COPA is likely to have a negative impact on patients." (staff comments at 22-25) Meanwhile, staff provide no evidence from any analysis they have conducted of state regulated mergers under similar statutes. Their lack of evidence or analysis makes it impossible for staff credibly to assert that a merger under the cooperative agreement statute, with commitments supervised by the state, would lead to diminution of quality. In fact, the Parties have provided evidence to support that Mission Health's recognition as one of the highest value health systems in the nation, multiple year recognition as one of the top 100 hospitals in America by Truven Health Analytics and recognition as one of the top 15 health systems in the nation by Truven Health Analytics, implies that after 20 years operating as a merged system under a COPA, quality was in fact not impaired. Staff's argument here amounts to nothing more than second-guessing by staff of Tennessee's sovereign Tennessee policy to supplant competition with regulation for qualified health care mergers, and should be ignored.

So, too, should staff's arguments that the Parties' will not improve quality through the merger. They claim "substantial empirical literature . . . does not support the conclusion that hospital consolidation generally improves clinical quality of healthcare services." (comments at 31) Even if this were true, it is irrelevant, because the general result of hospital consolidation research says nothing about the merits of the specific merger outlined in the Application – a merger with enforceable commitments under active supervision by the State. The Application addresses the benefits to flow specifically from the integration of Mountain States and Wellmont into the New Health System.

[52]Even very small changes in the risk profile of payers with very small numbers of covered lives could cause substantial changes in relative costs.

Staff cite only three articles from the so-called "substantial" body of literature. Upon review, the cited literature is far from comprehensive. One article, by Romano and Balan, is co-authored by a staff economist and addresses a single traditional merger that happened in 2000 in a Chicago suburb. (*Id*. at 31 n.116) Of the other two articles (*id*.), both co-authored by Professor Gaynor, one draws heavily for its conclusions from review of studies of the U.K. health system. The FTC relies on these, even though the authors concede "it is not possible to draw direct conclusions about the United States based on evidence from the United Kingdom."[53] Professor Gaynor et al. point out that their studies concern "the relationship between hospital *consolidation* and quality." They are careful to clarify what they mean by "consolidation":

> It is important to distinguish between consolidation and integration. *Consolidation* is simply bringing together two (or more) previously independent entities. *Integration* implies more—in particular, elimination of unnecessary duplication, creating systems to bring the previously separate entities together, and comprehensive management of the organization as a whole.[54]

The authors' definition of "integration" describes the proposed New Health System as detailed in the Application. But apparently the authors did not study mergers such as the proposed New Health System. They also did not evaluate mergers under a COPA/cooperative agreement arrangement. Accordingly, they warrant no weight in the record.

Staff's assertions that quality will suffer under the merger are baseless for other reasons as well. They ignore the substantial importance of national quality measures, payment incentives and penalties, and the fact that reimbursement through value-based purchasing and similar programs are increasingly tied to these quality measures and not performance versus another hospital in a particular area. For example, the declarant from Anthem supplied by staff states, in regard to Anthem's "Q-HIP®" quality performance program, that "Anthem reduces the base reimbursement rate of a provider that participates in Q-HIP® with the expectation that the provider has the ability to obtain a higher rate if it meets certain thresholds." (staff comments at App. A, ¶60) Hospital reimbursement from federal and commercial payers is an increasingly important source of incentives for hospitals to improve quality, and the merger will not change that.[55]

Staff attribute incentives to innovate and expand service lines to competition (staff comments at 23) but competition can also lead to unnecessary cost and duplication of core services, which reduce resources available for innovation or expansion. By reducing unnecessary duplication, the New Health System will be better positioned to invest in expanded

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[53]Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update*, ROBERT WOOD JOHNSON FOUND., THE SYNTHESIS PROJECT, Policy Brief No. 9, Attachment C at 3 (2012), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261. Despite this devastating admission, the authors incongruously add that the same U.K. studies "add to the growing evidence base that competition leads to enhanced quality under administered pricing."

[54]Gaynor & Town. The third article reviews other studies, with mixed findings.

[55]For example, the CMS Hospital Readmission Reduction Program is part of the federal government's announced goal to tie an increasing share of traditional Medicare payments to quality or value in the coming years. *See Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program*, KAISER FAMILY FOUNDATION (Sept. 30, 2016), *available at* http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/.

services not currently offered by either health system independently, and it has committed to make a definitive investment of $140 million in those services. Staff also erroneously contend that the merger will result in reduced access and quality in regard to certain physician specialty services. (staff comments at 22) They ignore the Parties' commitment under the Cooperative Agreement to make large expenditures ($140 million over ten years) to ensure ongoing physician needs assessments in the region and to work with independent and employed physicians to provide the needed services for access by rural patients.

2. The Commitments Ensure That Quality, Population Health Status, Innovation, Investment, Patient Access, And Quality Reporting Will Improve

The Department should evaluate staff's criticisms of the Parties' commitments on quality, population health status, innovation, investment, patient access, and quality reporting in the context of the Application taken as a whole, and especially in the context of the specific region in which the New Health System will operate. The Application represents an integrated set of commitments and actions by the New Health System that addresses fundamental health issues and priorities in Northeastern Tennessee (and Southwest Virginia) that take into consideration the unique features and challenges of this region, and that will be subject to active supervision by Tennessee (and Virginia). Furthermore, staff greatly overstate the complexity associated with the reporting and action requirements of the commitments. These are straightforward and enforceable commitments.

Staff's submission is premised on the mistaken belief that the current relationship between the Parties provides adequate health care services to address the critical health needs of the diverse and largely rural population in the region and that the $450 million in additional health care investment and other commitments by the Parties are not needed in this region. The Application, however, is not a federal antitrust matter, but an important issue of state public policy, with oversight and supervision by state authorities focusing on improving health care for a local population with significant needs.[56] Staff do not dispute the principal factual justifications for the merger set forth in the Application. These include:

- Northeast Tennessee disproportionately suffers from serious health issues, with higher rates of health risks than the State overall in such areas as obesity, blood pressure, cholesterol levels and substance abuse. (Application at 8, n.4)
- There is a very high percentage of Medicare, Medicaid, Medicare managed care and uninsured patients, with continuing downward pressure on Medicare and Medicaid reimbursement, even as labor and supply costs increase. Moreover, the Medicare Wage Index is one of the lowest in the nation, which leads to substantially lower reimbursement than peer hospitals in other states and in Tennessee for the exact same services. (Application at 34, 44)
- Inpatient utilization is declining and the population in the area overall is declining, resulting in less utilization of inpatient facilities.

[56] In their comments, staff rely on Dr. Kizer for support (staff comments at 37), but provide no further information about the bases of his opinions. There is no evidence Dr. Kizer has awareness of the issues in Northeast Tennessee, the consideration of these issues by the Legislature or the investments being proposed by the health system to address quality and population health issues in the region. Accordingly, staff's reliance on this individual should not be considered.

- There is a small and shrinking base of commercial patients, again with downward pressure on reimbursement.
- The Parties' small rural hospitals individually have very low patient volumes and contribute very little to the Parties' combined shares, typically just one or two percent per hospital. (Application at 21-22)
- Patients are willing to leave the Parties Geographic Service Area to obtain services elsewhere, particularly for specialty services. (Application at 22).
- The hospitals have duplicative health care resources.
- All these factors point to a declining revenue stream which does not support. growth in capital investment or even sustainability of the current cost structure.

Staff challenge some of the quality commitments as unsubstantiated, speculative or modest in scope, ignoring the fact that many of the commitments will require collaboration with the Tennessee Department of Health to ensure they are aligned with the Department's and State's goals. Once established and agreed upon, the State will actively supervise to ensure these commitments are met. Importantly, there are many quality and health improvement commitments which are not challenged by staff. They include the preparation by the Parties of a comprehensive template community health improvement plan that identifies key strategic regional health initiatives, prepared in conjunction with the Department and its staff, and feedback from the Community Health Work Groups (discussed below) and academic partners.[57]

The template community health improvement plan was prepared, in part, based on feedback from four Community Health Work Groups created by the Parties, comprised of community leaders and representatives. The groups held a number of town meetings throughout the region over the last year. These four groups have focused on four very important issues in the region – Mental Health & Addiction, Healthy Children & Families, Population Health & Healthy Communities, and Research & Academics. (Application at 89-91) Staff recognize the importance of this initiative (staff comments at 39-40), but misleadingly argue that the initiative shows the Parties can collaborate without a merger, ignoring the express statement in the Application that this initiative is being undertaken only in conjunction with the Cooperative Agreement and that the work and recommendations of the Community Health Work Groups cannot be implemented without the savings generated by the merger. (Application at 89)

Moreover, staff do not challenge the need for the following health improvement initiatives, which the Parties have committed to fund with an investment of not less than $75 million over ten years under the active supervision and oversight of Tennessee and Virginia:

- **Ensure strong starts for children** by investing in programs to reduce the incidence of low birthweight 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.

[57]The plan was prepared in conjunction with the public health resources at East Tennessee State University. See Application at 14; 50-3.

- **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.[58]
- **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.

(Application at 49-50)

The Application provides comprehensive commitments addressing fundamental health issues and priorities in Northeast Tennessee that compel the need for highly integrated and organized solutions led by the New Health System in close collaboration with community leaders and under the direct supervision of the State. The Application describes how the development of the integrated health care delivery system will align and sustain clinical services and professionals to meet area needs, and how the $450 million investments in health care programs, quality and best practices initiatives, infrastructure, organization, systems, and focused efforts to improve access and care, under active supervision by the State, will achieve a result for this region that negates staff's contention that the substantial benefits of the Cooperative Agreement are not needed. Importantly, the Application's objectives are closely aligned with the policy and goals of the Hospital Cooperation Act, along with the State Health Plan goals.

Staff's submission largely fails to consider any of the specific health care issues in this region, and asserts that a hypothetical construct of federal antitrust policy could work anywhere – whether urban or rural. In raising issues with regard to specific commitments or the alternatives available outside of the Application, staff do not address the specific issues facing Northeast Tennessee, and ignore the priorities that are well established by the Tennessee Department of Health and the Legislature. Staff further disregard the substantial new investments required to address the region's health needs and improve access, quality, and cost of care delivery.

a. Staff Ignore Key Facts About Northeast Tennessee

The region faces critical health issues, the resolution of which are Tennessee's highest priorities in order to improve health, access, cost, quality, and outcomes: *Southwest Virginia and*

[58] As discussed below, staff does challenge the need for additional behavioral health services in the area, referring to a proposed facility in Gray, Tennessee, approximately 25 miles from Bristol, Virginia, but as much as 90 minutes from some of the Virginia markets that would be served by the New Health System.

Northeast Tennessee disproportionately suffer from serious health issues.[59] The cost of this poor health is not sustainable for the well-being of the region's communities.

This region is a unique geographic area that requires a unique solution to its significant health care challenges. With the approvals of Tennessee and Virginia, under the Tennessee Hospital Cooperation Act, and the corresponding Virginia statute, savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the communities there. These benefits will include new services and capabilities, improved choice and access, more effective management of health care costs, and strategic investments to address the region's most vexing health problems while spurring its economic development. Approval of the Application provides a "unique solution for a unique region." (Application at 8)

Staff's submission only tangentially refers to the specific geography, population, and health issues facing Northeast Tennessee and ignores the substantial health care challenges of the area, of which the Parties have first-hand knowledge. The majority of residents of the counties served by the New Health System live in areas classified as rural;[60] and sixteen of the counties in the overall Geographic Service Area (excluding the Independent Cities) are more than 50 percent rural.[61]

The Application factually demonstrated that the region served by the Parties faces significant, wide-ranging health care challenges that are of specific concern and high priorities for Tennessee government authorities, and the Application specifically addressed those issues. As noted previously, the Tennessee counties served by the New Health System face many critical issues, including tobacco use, obesity, teenage pregnancy, low birthweight babies and substance abuse issues:[62] Only two of the Tennessee counties rank in the top half in Tennessee for overall health. (Application, Table 8.1 at 31). The Northeast Tennessee statistics show serious issues:

(1) Tennessee ranks 47th in the country in smoking rates.[63] A 2015 Tennessee Department of Health report finds that all the Tennessee counties exceed the

[59]Tennessee county-level data for the region is available at TENNESSEE DEPT. OF HEALTH, DIVISION OF POLICY, PLANNING, AND ASSESSMENT, 2015 DRIVE YOUR COUNTY TO THE TOP TEN (July 2015), available at https://www.tn.gov/health/topic/specialreports. The Southwest Virginia Health Authority's original *Blueprint for Health Improvement & Health-Enabled Prosperity* stated "[The LENOWISCO and Cumberland Plateau] planning districts have higher rates of health risks than the Commonwealth in obesity, blood pressure and cholesterol levels." The Authority's recently updated (Jan. 7, 2016) Blueprint goals for the region included these ongoing health issues. Virginia data is available at UNIVERSITY OF WISCONSIN POPULATION HEALTH INSTITUTE, *County Health Rankings & Roadmaps*, *available at*: http://www. countyhealthrankings.org/.

[60]The majority of the New Health System's Geographic Service Area residents (over 500,000) live in areas defined as rural, and All reported measures were obtained from the US Department of Health and Human Services' Area Health Resource File, a dataset that compiles data collected by other entities (*available at*: http://ahrf.hrsa.gov/). Total Population is from the U.S. Census Bureau, *2010 Census Redistricting Data, Summary File* (Pub. L. 94-171). Rural residency is available from the *Census of Population and Housing: Summary File 1 (SF1) Urban/Rural update*.

[61]The statistics for all of the counties in the Geographic Service Area may be found in Table 5.1 of the Application.

[62]All references to "Tennessee counties" refer to counties in the New Health System's Geographic Service Area.

[63]UNITED HEALTH FOUNDATION, *Tennessee State Data*, America's Health Ranking (Annual Report 2015), *available at* http://www.americashealthrankings.org/TN.

national average for smoking, and seven of the ten Tennessee counties exceed the state average for smoking.

(2) The state level obesity rate exceeds the national average, and several of the Tennessee counties have obesity rates of more than 30 percent.

(3) Tennessee is 42nd among states in rates of teenage birth,64 and yet not a single Tennessee county in the Geographic Service Area has teenage pregnancy rates below the state average.

(4) Three of the Tennessee counties are in the bottom third (worst group) for frequency of low birthweight births

(5) Only a single Tennessee county in the Geographic Service Area is below the State average for deaths from drug poisoning. (Application at 31)

The Tennessee County Health Rankings submitted in the Application (Exhibit 8.1 at 31) demonstrate that physical inactivity, obesity, tobacco abuse and substance abuse are major health challenges that disproportionately impact residents of Northeast Tennessee, and are associated with other health challenges and conditions. Additionally, the County-Level Data in the Application provide key statistics on the population in all Tennessee counties in the service area, and Tennessee state-wide averages for physical inactivity, obesity, tobacco use, and substance abuse. (Application, Exhibit 8.2 at 33) The county-level data show that most Tennessee Counties in the region exceed the state average in at least three of these categories.

The data on health conditions and issues in the Tennessee counties are repeated here to emphasize the alignment of all aspects of the Cooperative Agreement Application and commitments to the specific issues of importance for the residents of this area that are driving total cost of care now and in the future, and the critical importance of needed investments in the region to address cost, quality and access to care in a sustainable fashion. As was noted, the Parties share the State's concerns about these significant health issues. These issues are among the key areas of focus within the scope of the current Community Health Work Groups. Staff's submission does not address or even appear to recognize these critical priorities and issues that form the baseline for concerted action and investments by the Parties, under the continuing oversight and supervision of Tennessee.

b. Staff's Comments On Quality-Related Commitments Are Baseless

Staff question whether the proposed merger and certain commitments are likely to achieve outcomes superior to those of "likely" alternatives, including no merger, acquisition of one or both Parties by other entities or systems from outside the area, or collaboration or joint venture arrangements between Wellmont and MSHA in specific areas.[65] While staff suggest there may be alternative collaborative efforts short of a merger, staff provide no detail and no guarantee that either the FTC or private parties will not challenge such alternative efforts on antitrust grounds. Such alternatives would require sharing of very confidential cost and price information and require agreements between the Parties on the services that each would offer and

[64]UNITED HEALTH FOUNDATION; *see also* U.S. Dept. Health and Human Services, *Trends in Teen Pregnancy and Childbearing*, Office of Adolescent Health, *available at,* http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy/trends.htmlv (search "Trends in Teen Pregnancy and Childbearing").

[65]Many of the specific commitments made by the Parties are not challenged by staff.

not offer, agreements on which facilities to keep open, close, downside or repurpose and agreements on the number and compensation of specialists and subspecialists.

Similarly and importantly, while a merger with an out-of-market system may produce some efficiencies, as staff contend (staff comments at 45), any such synergies would likely benefit the out-of-market acquirer, not the local region, and would certainly not rise to the level of synergies achievable between the Parties through elimination of unnecessary duplication of cost. These synergies have been validated by independent analysis, and such analysis is in the possession of the State. The Parties' plan is to invest the hundreds of millions of dollars of merger savings locally in order to improve health care, as detailed in the Application.

Staff specifically challenge the benefits from consolidation of certain services and facilities that would reduce duplication, produce cost-saving efficiencies that would fund other needed services and improve patient outcomes by increasing volume. The cost of maintaining duplicative facilities in close proximity to each other, including maintaining three hospitals in Wise County, Virginia with daily censuses of 35, 13 and 10, is ignored.[66] Because of decreasing reimbursements and the other challenges mentioned earlier, it will be increasingly difficult to continue to sustain these facilities over the long-term without the savings the proposed merger would create.

As an example of the duplicative services that the New Health System can potentially integrate to generate efficiencies, the Parties referenced the area's two Level I Trauma Centers, which are redundant in a region with low population density. (Application at 38) No other region in Tennessee operates two Level I centers. Staff do not challenge the cost-savings potential from such integration, but ignore the fact that the savings generated could instead be invested in more needed services for the region such as pediatric trauma.[67] Staff also dispute the potential for clinical quality enhancement that would result, and hypothesize about potential patient inconvenience.

Citing only to one article (co-authored by a staff economist) concerning one hospital merger from 17 years ago, staff claim that the "research literature shows" that a volume/outcome relationship exists only for certain procedures and services, but allow that one such service is trauma. (comments at 32 & n.119) Staff say no quality benefit will result from merging the Mountain States and Wellmont trauma centers, because, based on a study the Parties identified in the Application, each center has already reached the volume level where the volume/outcome relationship ceases. (*Id*. at 32) [68] Staff take the unduly narrow view that enhanced clinical quality from a merger is a function only of volume.

[66]Based on the 2013 data. See Application Tables 5.2 and 5.3 at 17-19.

[67]No decision has been made on consolidation of any facilities; the reference to the trauma centers was merely an example.

[68]Staff cite Avery B. Nathens et. al., *Relationship Between Trauma Center Volume and Outcomes*, 285 J. AM. MED. ASS'N 1164 (2001), *available at* http://jama.jamanetwork.com/article.aspx?articleid=193615). Staff make numerous errors in interpreting the results of this study. The study actually concludes that crude mortality rates continue to fall as volume increases beyond 650 cases per year for patients with shock (see Figure 2 – Panel B). The use of the term threshold was misunderstood by staff. It did not indicate that the beneficial effect of higher volumes weakened at that point, but was used to separate low-volume trauma centers from high-volume trauma centers.

The Parties provided this literature showing high-volume trauma centers produce better outcomes (Application at 45) to demonstrate the medical community's focus on trauma service, recognizing that it requires substantial capital investment, dedicated teams, and equipment. Staff's comments fail to recognize the critical resources that elimination of such duplication provides – scarce resources that can be allocated much more effectively to provide and sustain care delivery in the region which is not currently available. Many reasons explain why clinical outcomes are likely to be superior if the trauma centers are integrated, including sustained resources, greater specialization by individual teams, and the ability to maintain capacity in a single location dedicated to all these services. Moreover, there are no guarantees that either or both facilities would maintain volumes at current levels. Staff speculation about additional travel time to reach a trauma center, moreover, ignores the fact that most major trauma patients are transported by helicopter so the difference in time may not be material and that emergency room services will remain at the hospital that closes the Level I Trauma Center. Staff also fails to consider that Tennessee contains only six hospitals with Level I trauma centers, in the metropolitan areas of Knoxville, Chattanooga, Nashville, Memphis and the Tri-Cities. The Tri-Cities area is the only region in Tennessee with two Level I centers.

As noted by the Parties in the Application, health care services offered by rural hospitals are at increasing risk of closure, with 80 rural hospitals closing since 2010, including eight in Tennessee and one in Virginia.[69] The Parties collectively invested more than $19.5 million last year alone to ensure that inpatient services would remain available in smaller communities. (Application at 43) The Parties have committed that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years and that the New Health System will continue to provide access to health care services in the community thereafter based upon the demonstrated need of the community. This commitment to maintain access in these communities does not exist without the merger.

In the same vein, staff attempt to minimize the multimillion dollar commitment to develop specialty centers and pediatric emergency rooms in Kingsport and Bristol and to add rotating pediatric specialty clinics in rural hospitals. (staff comment at 49) Staff contend that the Parties offer some of these services already and the merger "may" not be necessary to achieve these improvements. The Parties made this commitment based on a specific needs assessment that identified a lack of pediatric specialists in the rural areas of the region. (July 13 Department Responses at 35-36) A large number of children in the region are covered by Medicaid, and the Parties recognize the difficulty many families have with transportation and the impact this has on access to care. These are all elements of a coordinated plan to address specific needs and to hold the Parties accountable.

It is misleading for staff to list all hospitals that offer pediatric services when pediatric specialists *do not* exist in these areas. Contrary to what staff say, the Parties believe that pediatric specialty centers and pediatric emergency rooms with connectivity to local hospitals are clearly needed. Also misleading is staff's reference to a partnership with a children's hospital in Knoxville (staff comment at 49), ignoring the fact that these families then have to drive one and a half hours or more to Knoxville because the specialists are not available in closer proximity.

[69] *See* THE CECIL G. SHEPS CENTER. Fourteen rural hospitals have closed since the Application was filed in February, 2016, including two rural hospitals in Tennessee.

The reality is that there are few pediatric specialists available in the rural areas of the region. When pediatric specialists are not available in a local community within the Geographic Service Area, children and their families must currently often travel to Johnson City or even beyond to seek care. The Parties' goal is to make pediatric specialty care as least disruptive as possible for those children and their families who need it, and to make it an integral part of the new integrated health care delivery system by combining the assets and complementary capabilities of the Parties. The merger would allow the Parties to improve access to pediatric specialists for smaller communities and reduce the travel time necessary for families to utilize these services. These services are closely aligned to state priorities.

Staff's contention that quality overall may diminish as a result of the merger is also without foundation. This contention ignores the well-established fact that reimbursement is increasingly tied to quality metrics, both for government-funded programs such as Medicare and commercial insurance. (Application at 7) Similarly, the New Health System cannot afford to lag in innovation. It must keep pace with new technologies and approaches to care, particularly with regard to more specialized services where it will continue to compete with out-of-area tertiary centers. That competition is both to provide high quality care for patients and to attract to retain or bring needed physicians and specialists to the region. Further competition will continue to exist, particularly for services where there is a need as determined by the Tennessee in the Certificate of Need process, or for services that do not require a Certificate of Need.

i. The Behavioral Health Service Commitments Are Very Needed

Staff do not deny that, as stated in the Application, behavioral health needs and substance abuse are prevalent in the region and that the largest diagnosis related to regional inpatient admissions is psychoses. (staff comments at 33) The Application describes in detail the necessary steps to address this pervasive and serious problem in the region, focusing on the significant gaps in the continuum of care related to these issues. The Application notes that the majority of these patients also experience physical health conditions or chronic diseases that complicate care needs. (Application at 53-54) Accordingly, these patients typically have higher levels of health care utilization, sometimes 2 to 3 times as high as for those who do not have a mental health/substance abuse disorder. (Application at 53)[70]

In recognition of this significant problem, the New Health System is committed to create new capacity for residential addiction recovery services connected to expanded outpatient services in the region and to 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. (Application at 56)

Staff attack this commitment, arguing that Mountain States and other organizations are already willing to develop new facilities, but cite a *planned* Mountain States/Frontier Health

[70]This commitment on behavioral health services is part of a $140 million commitment that also includes recruitment and retention of pediatric sub-specialists and development of pediatric specialty centers and emergency rooms in Kingsport and Bristol. (Application at 55)

facility in Gray, Tennessee, which is a significant drive from some of the areas served by the New Health System. The proposed project has been terminated. It was projected to reduce inpatient utilization for behavioral health and overall cost, but agreement could not be reached to obtain reimbursement for outpatient services. Staff also cite a July 12, 2016, news story, but that story relates to postponement of a zoning vote on a potential ETSU methadone clinic site. ETSU and MSHA agreed to let elected officials consider alternative locations to the Gray Commons site targeted by the Parties. While staff apparently recognize the serious need for behavioral health services, its hands-off and hypothetical solution ignores the needs of the region.[71] Their argument also fails to recognize the magnitude of the planned investment by the Parties, which is envisioned to be the most comprehensive effort to meet regional needs to date and is far beyond the creation of a few isolated clinics of discreet and disconnected approaches. The plan is for more than a facility or a program, it is for the development of a comprehensive and organized program for which the Parties will be accountable.

ii. Common Clinical IT Platform Improves Quality And Saves Costs

The Parties have committed to a Common Clinical IT Platform to provide better coordinated care and committed to participate meaningfully in a health information exchange open to community providers. Staff's opposition lacks credibility. They argue that each hospital system has well-functioning electronic health records ("EHR") systems that are fully integrated within their respective hospitals (comments at 35), ignoring the fact that the commitment is for a Common Clinical IT Platform ***between*** the hospital systems.

Staff speculate that such a Common Clinical IT Platform would not benefit patients who choose to use only one hospital system (*id*. at 36), thereby conceding that a Common Clinical IT Platform would benefit the large number of patients who could now utilize all the hospitals within the new system based upon convenience and other factors. They also suggest that such a Common Clinical IT Platform should be done with an entity other than a competitor (*id*.), ignoring the fact that a Common Clinical IT Platform with an out-of-market system would be of no utility to coordinating care region-wide. Staff's skepticism of the value of a Common Clinical IT Platform is directly contrary to federal policy attempting to increase interoperability and also the benefits of common platforms.[72]

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[71] Staff's statement that the Parties' plans regarding behavioral health services "should be viewed skeptically in light of their efforts to prevent other providers from offering such services" is misleading and inapplicable. (staff comments at 34) MSHA has opposed construction of a for-profit inpatient psychiatric facility (which SBH admitted in its Certificate of Need ("CON") application would consist only of fewer than 5 percent TennCare and charity patients) because the facility would be detrimental to the only inpatient psychiatric institution serving the region – where 50 percent of its patient days serve TennCare and charity patients. The new facility would not focus on this needy population, and its service offerings were limited to the profitable services and not necessarily the most severe needs and demands of the region. MSHA executives testified under oath that the needs in the community are not for basic inpatient psychiatric services, but rather, investment into community-based, outpatient mental health services, which, if deployed, would actually decrease the need for additional inpatient and costly beds. The Parties' commitments are designed around investment into community based-outpatient services located closer to where individuals live and work. Staff never make these important distinctions. Moreover, the Parties plan to invest in additional capacity for residential addiction treatment, a service distinct from standard inpatient psychiatry. Such a facility does not currently exist in the region – a part of the country severely impacted by the opioid epidemic. Conflating this need with the CON application by SBH is a misappropriation of facts.

[72] *See "HHS Publishes a Roadmap to Advance Health Information Sharing and Transform Care*," U.S. Department of Health & Human Services Press Release (October 6, 2015), *available at* http://www.hhs.gov/about/news/2015/10/06/hhs-publishes-

Currently, there is no Common Clinical IT Platform in the region, and instead two separate platforms at Wellmont and Mountain States, with different protocols, data requirements, and approaches. A Common Clinical IT Platform yields several benefits, including better implementation of common protocols and best practices, secure collection and dissemination of key data and information, and substantial resource conservation supported by common data analytics and staffing that otherwise would be replicated by the two systems. This is particularly relevant for the Geographic Service Area which is largely rural, lower income, and facing lower reimbursements than many other areas in the country. Given the specific significant health care issues, and the large number of communities to be served by predominantly smaller hospitals, physician offices, and clinics, this common infrastructure and platform in combination with a region-wide Clinical Council discussed below, which will align capabilities and information around needed changes and reductions in clinical variation that will reduce costs and improve outcomes.

The New Health System will establish a system-wide, physician-led Clinical Council in order to identify best practices that will be used to develop standardized clinical protocols and models for care across the New Health System. As described in the Application, the Clinical Council will be composed of independent, privately practicing physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates as more fully described in Section 8.A.iii of the Application. It would not be possible for the two competing systems to standardize procedures and policies for clinical best practices as effectively, or to develop such new care models, absent the merger. (Application at 77) These standardized practices, models and protocols will help reduce clinical variation and overlap, shorten length of stay, reduce costs, and improve patient outcomes. The Cooperative Agreement will allow the New Health System to share the clinical and financial information needed to integrate this process across the range of inpatient, outpatient, and physician services.

Staff agree that clinical standardization can improve quality but contend that it can be accomplished unilaterally or through a collaboration short of a merger or an out-of-market merger. (comments at 36-37) Standardization across the New Health System, however, collaborating under common governance and the shared resources of an integrated organization, would generate substantially greater savings and quality enhancement opportunities than separate, intra-system standardization, a limited collaboration of the type identified by staff, or an out-of-market merger that cannot offer the same magnitude of merger-specific system-wide efficiencies.

Many of the initiatives to reduce variation and improve quality will be derived from or enhanced by new contracting practices designed to ensure collaboration and alignment of incentives around outcomes and costs savings between the New Health System and the payers. These practices will use the input from the payers to identify high cost services and processes, and then align the interest of the payer and the New Health System to reduce cost and improve the overall patient outcome. The Common Clinical IT Platform and the Clinical Council will be used to establish and monitor compliance with these best practices. This approach to value-based purchasing is consistent with changes in federal policy that encourage improved population health. The objective is to identify opportunities for patient outcome improvement

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roadmap-advance-health-information-sharing-and-transform-care.html.

and cost reduction, and then to collaborate with physician leadership to execute legitimate and scalable strategies throughout the region to achieve the mutual objectives of the payer and the health delivery system. (Application at 78)

The significant benefits from the Common Clinical IT Platform and supporting investments/activities include:

- Allows for best practices and actions to be focused on the region's highest health priorities and risk factors, and align the quality of care across all facilities for common services.
- Common data on a single platform provides for all to access data easily across the region. The ability to share data across all providers for a unique patient provides improved ways to reduce avoidable readmissions, and avoid unnecessary and redundant tests with important cost and quality benefits.
- Common data supports and enables new efforts to have best practices such as blood utilization or pulmonary embolism protocols across the region, which achieve superior results to fragmented approaches across multiple systems. With common IT platforms, all practitioners see same data and same information – and data can be made more robust with a common system.
- Detailed data and analytics on applying best practices and evidenced-based approaches can be accomplished at substantially lower average costs per patient if done with one system rather than with replication of two systems. These resources saved can then be allocated elsewhere. There is also the ability to apply more staff resources to dedicated analytics.
- Enhanced security and cybersecurity with one system, an important concern.
- In an area with so many independent physicians, a common IT platform reduces the costs and complexity associated with physicians needing to access two completely different systems with potentially two different protocols and best practices – and with higher costs.
- Community clinical variation is a critical issue in this region; with the Common IT Platform and Clinical Council there will be the same information and same drivers to direct evidence-based care. Significant decreases in clinical variation – across a region – will yield very substantial benefits to patients and payers.

Staff also argue that the merger is not necessary to implement a health information exchange ("HIE") and the local HIE developed by local physicians can be a substitute for a robust regional HIE supported by the New Health System's Common Clinical IT Platform. (comments at 37) While the OnePartner HIE system is useful in reaching out to independent physicians, the system is limited in the data that it can transmit. There is a significant difference between a regional HIE supported by a Common Clinical IT Platform and the current OnePartner system, or any other HIE. The proposed Common Clinical IT Platform will be able to collect significantly more detailed patient information, including order entry, nurse notes, and medication reconciliation along with additional analytical capabilities for population health management.[73]

[73] *See Responses to Questions Submitted April 22, 2016 by Tennessee Department of Health in Connection with Application for*

iii. Greater Transparency In Quality Reporting Is A Major Benefit

The Application describes a wide range of comprehensive quality metrics which the new system will publicly and timely report. Staff do not question the important value of this extensive quality reporting, which go well beyond what most hospitals report with regard to timeliness and completeness. Instead, staff assert that nothing prevents either hospital system from taking these steps now while they remain independent. By increasing transparency in reporting of data, the health system will hold itself to a higher standard than either system is being held to today. Staff's argument misses the purpose of reporting the extensive quality measures – to hold the new system publicly accountable for achieving and maintaining quality under a Cooperative Agreement actively supervised by the State.

The specific commitments on quality reporting are detailed, transparent and provide the ability for regulators and the public to hold the New Health System accountable. In particular, the New Health System will commit to publicly report on its website:

- The New Health System's CMS core measures[74] for each facility within thirty days of reporting the data to CMS. The New Health System will also provide benchmarking data against the most recently available CMS data so the public can evaluate and monitor how the New Health System facilities compare against hospitals across the state and nation in a manner that is more "real time" than currently available. Publicly reported CMS Hospital Compare measures, by category, along with the number of measures in each respective category were provided in the Application at Table 15.3. These demonstrate the breadth of commitment by the New Health System to provide comprehensive and timely information for benchmarking and accountability.
- Its results on core measures and do so several months earlier than CMS customarily makes the information available to the public. Currently, there is an approximate six-month lag between when core measures are reported to CMS and when CMS posts the information for the public. The New Health System intends to empower patient decision making by reporting core measures in advance of the federal agency reporting.
- To ensure patients have information on the latest CMS core measures, all current CMS core measures, rather than a pre-defined set of measures chosen by the Parties.[75] CMS periodically changes the core measures it requires hospitals to report.

Certificate of Public Advantage, at 10-11 (July 13, 2016), *available at* http://tn.gov/assets/entities/ health/ attachments/ WHS-MSHA_April_22,_2016_DOH_Response_1.pdf.

[74]CMS Hospital Compare metrics are publicly available at: https://data.medicare.gov/data/hospital-compare. As indicated in Table 15.3, there are seventeen categories of measures and each category contains a set of measures. For example, Readmissions & Deaths is one of the 17 Hospital Compare measure categories. This category contains fourteen individual measures including, for example, AMI 30-day mortality rate, Pneumonia 30-day mortality rate, and the Rate of readmission after discharge (hospital-wide).

[75]The New Health System will commit to using the same standards of reporting as CMS and reserves the right to not report those core measures that would not be reported by CMS (e.g. too few patients for the metric to be statistically significant, protected health information concerns with the metric being reported, etc.).

- Measures of patient satisfaction for each facility within thirty days of reporting the data to CMS via the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") reporting. The New Health System will also provide benchmarking data against the most recently available CMS patient satisfaction scores so the public has access to how the New Health System facilities compare against hospitals across the state. The New Health System's results will be available on its website and reported several months earlier than CMS customarily makes the information available to the public.
- Specific high priority measures for each facility annually, with relevant benchmarks. The high priority measures are set by CMS[76] and the Joint Commission and have in the past included: Central Line-Associated Bloodstream Infections, Catheter-Associated Urinary Tract Infections, and Ventilator Associated Pneumonia Infection Rates.
- Surgical site infection rates for each facility annually.
- The ten most frequent surgical procedures performed (by number of cases) at each Ambulatory Surgery Center in the system annually. Studies have shown that facilities performing high volumes of a procedure may have better outcomes than those performing low volumes. The New Health System intends to be transparent about the volume of procedures it performs and the outcomes related to those procedures.
- In an effort to improve transparency and reporting on high priority measures for quality and cost, annual reports of the following information by facility, aggregated for the facility across the DRGs that comprise 80 percent of the discharges from the New Health System facilities:[77] Severity adjusted cost/case; Length of stay; Mortality rate; and Thirty-day readmission rate.
- These quality measures for the top ten DRGs aggregated across the system annually. By reporting on these quality measures specific to each of the top 10 DRGs for the system as a whole, the New Health System is committing to a new level of transparency and accountability for care in the service lines that account for greatest usage by the population. The top 20 DRGs by system for 2014 were provided in the Application at 15.4.

In addition, the New Health System will select a third-party vendor and provide the data for the vendor to analyze the severity adjusted measures and post them to the New Health System's website.

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

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

All of these commitments demonstrate the willingness of the Parties to engage with payers, regulators, consumers, and the community to provide substantial information on quality in a usable form for use in contracting, consumer decision-making, and clarity of performance across the entire New Health System. In addition, the Parties have committed to reporting on its health initiatives and programs.

iv. Staff Ignore The Impact Of Increasing Incentive-Based Payments Which Influence Improvement In Quality And Value

Staff minimize the effect that incentive-based payment will have on sustaining improvements in quality. These new payment mechanisms are a powerful impetus for the New Health System to continue investing in enhanced quality. For instance, the American Hospital Association points out in its report *Care and Payment Models to Achieve the Triple Aim*, the AHA states that "…hospital leaders are designing new care delivery systems. Adoption of these new systems can be facilitated by new and innovative payment models that center on individual and community needs and reward high-quality care with desired individual and population health outcomes. Recent changes to Medicare reimbursements support building a care delivery system based on quality and value-based payment policies. The U.S. Department of Health and Human Services has set a goal of tying 30 percent of all traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models by the end of 2016, and tying 50 percent of payments to these models by the end of 2018."[78]

As the payment system shifts to increasing use of quality incentives designed to improve value, the New Health System has significant incentive to improve, not diminish, quality. With 70 percent of the New Health System payments being derived from government programs which base the reimbursement on Medicare, it is clear that the New Health System faces great financial peril if it should permit value or quality to deteriorate. This pressure supplements regulatory oversight and aligns the Parties with commercial payers.

Staff contend without foundation that the Parties' are not more likely to engage or be more successful in value-based contracting despite the New Health System's enhanced scale. (comments at 40, 42)[79] Staff do not acknowledge that virtually every payer is investing in value-based models that reward measurable quality, and the incentive this creates for the New Health System to utilize its scale to achieve greater savings and quality. The Parties' commit to devoting significant resources to eliminating clinical

[78] *See* American Hospital Association Committees on Research and Performance Improvement, *Care and Payment Models to Achieve the Triple Aim,* AMERICAN HOSPITAL ASSOCIATION (2016), *available at* http://www.aha.org/content/16/care-payment-models-achieve-triple-aim-report-2016.pdf.

[79] Staff refer to two studies that purportedly support this contention. (staff comments at 41 n. 165) One study, by Kaul *et al.,* finds "no relationship between size and cost" for health care systems comprising multiple facilities. (*Id*.) The authors state, however, that the "primary explanation for the absence of scale economies is that healthcare systems are often run as de facto holding companies — i.e., a collection of highly autonomous hospitals — rather than as integrated organizations that have standardized procedures and systematically reduced costs." A "de facto holding company" is the precise opposite of what the New Health System will be. The Parties have committed to a process of standardizing procedures and systematic cost reduction and will be held to these commitments by the State. The other study to which staff refer (Muhlestein *et al*.) concerns ACOs – partially integrated groups and not full-scale heath system mergers that offer a far greater opportunity for cost savings.

variation and establishing regional standardization in care plans developed by physicians partnering with the System in the Clinically Integrated Network. Resources are required to develop the data, the analytics, and the processes that can be implemented across the entire system.

The Parties will improve quality by using the data available through a common EHR and through strategies by the physician-led Clinical Council, which has direct linkage to the Quality Committee of the New Health System, and through deployment of quality initiatives applicable to the critical mass of patients with whom the System will have contact. These commitments, along with increased transparency and the move toward increased value based models of reimbursement that align quality goals and incentives with the payers, will have a powerful effect on quality and foster the benefits to be derived from value-based contracting.

The merger will also enable the Parties to advance toward risk-based relationships with payers. With a single balance sheet and aligned financials across the entire system, the Parties will be better positioned to take risk. It has been difficult for either system, alone, to enter into full risk based arrangements that blend quality with price. Mountain States attempted this with its own insurance plan, but Wellmont, as a competitor, never participated as a provider in the plan. As a result, Mountain States closed the insurance plan. The intent of the insurance plan was to gain enough critical mass of population to use incentive based payment to drive quality. The plan simply did not work because it could not generate the number of lives necessary to be sustainable. Combined, the Parties are more likely to be able to have the scale to accommodate risk-bearing, and some downside risk. Staff's claim (comments at 41) that certain limited pay-for-performance provisions in payer contracts today between each party and certain payers means that larger-scale value-based or risk-sharing contracts are not merger-specific is not supported by the facts.

v. Incremental Funding Of Academic And Research Opportunities Provides An Important Benefit

As detailed in the Application, the Parties will work with its academic partners and commit not less than $85 million over ten years to develop and implement post graduate training of physicians, nurse practitioners, physician assistants and other health professionals, to increase residency and training slots, to create new specialty fellowship training opportunities, to build and sustain research infrastructure and to add faculty. (Application at 69) These initiatives are all critical to sustaining an active and competitive academic training program, which will attract additional outside investments from state and federal government research dollars and other sources, a fact not disputed by staff.

The Application specifically states that the Parties have each been reducing the number of residency slots they have been funding due to financial constraints and that the savings generated by the merger will be used to reverse this trend. (Application at 69) For example, due to financial constraints, Mountain States has cut ten funded residency slots since 2012 and Wellmont independently reduced funding for residency slots as well. Because of the significant financial investment needed to sustain these programs, this trend will continue without the merger. Funding of residencies is key to providing improved health care in the region since approximately 40 percent to 50 percent of residents stay in the region upon completion of their

residencies. Importantly, the new system will be able to attract physicians interested in research and the planned expansion of research opportunities.

Staff do not question the importance of this academic funding and the fact the Parties have been reducing funding for residency slots. Contrary to staff's assertions, this $85 million funding is incremental and would not be possible in the absence of the savings from the merger. Staff also contend that the Parties already "invest significantly in healthcare education" (staff comments at 40), but do not dispute the importance of this additional funding. While staff complain that the commitments are not specific enough, they ignore the fact that Tennessee will actively supervise compliance with this important commitment.

vi. Staff's Claims Regarding Other Merger Benefits Are Also Unfounded

Staff's refusal to acknowledge a single benefit from the proposed merger continues well beyond the subjects discussed above. This serves only to underscore staff's disdain for the Hospital Cooperation Act and inability to evaluate the facts with objectivity.

They criticize the New Health System's preservation of hospital facilities as "only a limited commitment" that is insufficient in scope and detail. (comments at 42-43) Staff stretch to complain that the Application does not define the term "primary care services" or "commit to maintain any specific level of physician employment" at System facilities. (*Id.* at 43) To suggest, as staff do, that "primary care services" is a term of puzzlement to the Department, or that committing to a "specific" level of employed physicians would be a meaningful metric for the Application, betrays either a lack of understanding or lack of seriousness on staff's part. The Parties have spent many hours working with Tennessee (and Virginia) officials regarding the commitments, and are continuing to do so, to address any remaining concerns or open questions either State may have regarding the scope and content of the Parties' commitments.

Staff make another Merger Guidelines and antitrust-based argument in questioning whether any benefit results from the Parties' commitment to keep rural hospitals open, despite low or negative margins. (comments at 43) They argue that the Parties have not provided evidence that absent the merger they plan to close a hospital or curtail certain clinical services. This is tantamount to a rejection of a "failing company" defense – which the Parties have never made and which is not required under the Hospital Cooperation Act. The issue is not whether the hospitals are failing. It is whether hospitals are sustainable and capable of continuing to provide the same or improved levels of care absent the merger, including with its commitments. A major factor driving the merger is to preserve access to care, by utilizing the resources made available from merger-generated cost-savings to preserve facilities before they are on the brink of failure and market exit. This is the exactly the type of community benefit that the Hospital Cooperation Act reaches but antitrust law does not with respect to mergers that may be anticompetitive.

Later in their submission, staff repeat the claim that there are "less restrictive ways" than the merger to solve the economic and health problems in the Parties' Tennessee service area. Nowhere does staff provide an example from which to model an alternative strategy to achieve $450 million over ten years to fund the commitments that will benefit the community due to the

merger. (*Id.*) They identify three transactions in which an acquiring health system reportedly committed to spend substantial sums (hundreds of millions of dollars or more) to improve conditions at acquired hospitals. (*Id*. at 44 n.178) In citing these transactions, staff are not explicit in where the "hundreds of millions of dollars or more" comes from, which is relevant, since in many such acquisitions, the funds are generated from the cash flow of the acquired entity.[80] Staff also do not point out, however, that the only transaction alternative to the merger for either Party is an out-of-market merger, which (i) would not replicate the proposed merger's potential for efficiencies and community benefits, and (ii) would not be regulated and subject to a rate cap, such that its probable result would be higher prices.

Staff dispute the Parties' description of the merger's potential for efficiencies, which was aided by an independent third-party expert. Staff provide no empirical information to support its statements on this subject. (comments at 44-46) They state that "purchasing synergies and reductions in corporate overhead" from eliminating administrative duplication could be achieved by an out-of-market acquisition (*id*. at 45), which is true, but a high portion of those synergies would leave the area for the acquiring parent. More jobs would be lost by an out-of-market transaction. The New Health System will keep more jobs and keep the synergies local, and use the savings to fund programs to yield community benefits in the local area.[81]

With respect to improvements in utilization and the beneficial avoidance of unnecessary duplication from the proposed merger, staff offer another misguided criticism. They argue that current hospital infrastructure is the product of prior expenditures, which were possible only because the State found the expenditures necessary pursuant to the certificate of need (CON) process. From this, staff opine that the elimination of duplication is not a benefit because the duplication was determined to be needed. (comments at 46) This argument has no merit.

To the extent staff are accurate that certain duplicative resources once obtained a CON, the argument ignores the transformational changes in technology, financing and regulation in health care delivery over the last twenty years. The health care delivery landscape in our region today is far different from when many of the CONs were granted.[82] The record is replete with evidence showing our current pervasive health problems and economic challenges that did not exist in those earlier years – and calling for new solutions. But staff deny the merger's promise to improve utilization and benefit patients, and do so by retreating to their irrelevant policy

[80]In such circumstance, the acquiring entity is not, in fact, providing any new funding to the acquired hospitals, but merely using cash flow to fund the cash or debt service required to pay the costs of future capital expenditures. Typically, incremental cash flow is derived from some combination of increased pricing, elimination of local jobs as synergies are obtained, and other synergies related to purchasing of supplies or improved operations.

[81]Staff also contend that the benefits of the efficiencies may not be achieved because of significant cultural differences between the parties and rely on a gross distortion of an article by Dr. Sargent of Wellmont. (staff comments at 33) Dr. Kizer also grossly distorts this article in the same fashion, as discussed below. As demonstrated in the response to Dr. Kizer's comments, Dr. Sargent, who has practiced medicine here for 31 years and has witnessed firsthand the many significant health care challenges, strongly advocates for this merger in order to improve health care in this region, stating: "If our region doesn't fight for and seize this opportunity, no one will do it for us."

[82]As an example, consider that when Certificates of Need were initially required for Open Heart Surgery, many of the interventional catheterization procedures which eliminate the need for opening a chest did not exist. Today, Open Heart volumes are much lower than they were 20 years ago, thus reducing the need for more programs. As the technology involved with orthopedic surgery evolves, it is projected that many joint replacement procedures will become outpatient, and no longer require hospitalization. This will significantly reduce the need for inpatient beds. By the staff's argument, they are suggesting the beds are still needed, which demonstrates staff clearly have no grasp on evolving nature of health care.

choice of competition. They argue that "economic research indicates that hospital competition leads to lower costs" (*id*. at 46), that "competition is good for consumers" (*id*. at 47), and that "[e]liminating this competition could lead to a less productive allocation of resources" (*id*.). These claims are insufficient to overcome the compelling reasons to issue the COPA.

3. Summary Of Commitments

To assure the Department and the Commissioner of the overriding benefits of the proposed merger, the New Health System has made substantial commitments to the region that include the investment of hundreds of millions of dollars over the next ten years. The monetary and other commitments go well beyond any commitments made in the approved cooperative agreement/COPA that were granted in nearby states of North Carolina (Mission Health COPA) and recently West Virginia (Cabell Huntington cooperative agreement).[83] The monetary commitments are possible solely based on savings to be realized from merger efficiencies, and cannot be made without the merger. The commitments are evidence of the Parties' belief in the New Health System's ability to reduce cost growth, improve the quality of health care services and access to care, including the patient experience of care, and enhance overall community health in the region. The commitments are made to demonstrate clearly that the benefits of the Cooperative Agreement are not only likely to, but will, outweigh any disadvantages likely to result from a reduction in competition from the proposed Cooperative Agreement.

The Parties described the initial commitments in the Application and explained that the commitments were made specifically to demonstrate benefits and ameliorate disadvantages described in the Hospital Cooperation Act. Many of the commitments can be categorized into the following areas, which align with the Hospital Cooperation Act's list of potential benefits and disadvantages likely to result from a cooperative agreement:

- Improving Community Health
- Enhancing Health Care Services
- Expanding Access and Choice
- Improving Health Care Value: Managing Quality, Cost and Service
- Investment in Health Education/Research and Commitment to Workforce

The Application provides additional details on the commitments as well as the Parties' initial proposed benchmarks and metrics (or the process by which these will be identified) to measure the New Health System's progress toward achieving the commitments.[84]

Now that the Application has been deemed complete and the Department is reviewing the Application, the Parties have been engaged in productive dialogue with the Department about the commitments. Based on its extensive knowledge of the health care needs of the region, the Department has provided valuable input on some specific areas of focus for a set of broader commitments and ways in which achievement of these commitments can best be demonstrated

[83]Some states like Tennessee and North Carolina have called these agreements with the state Certificates of Public Advantage ("COPAs"), while other states like Virginia and West Virginia have called them cooperative agreements. They function in the same way.

[84]*See* Application 91-109.

and measured by the Department and the Commissioner on an ongoing basis after the Cooperative Agreement is approved. The Department and the Parties are considering potential revised commitments and achievement scoring mechanism based on these discussions. A number of the proposed revisions under discussion would make the original commitments stronger or clearer.

The discussions with Tennessee are ongoing as of this date. The Department's review of the Parties' proposed Cooperative Agreement has been and continues to be thorough and focused on the health care needs of the region it serves. Likewise, the Parties anticipate that the Commissioner, during his review of the Cooperative Agreement, may have additional input on specific focus of the commitments and how achievement of these commitments should be shown.

Staff criticize the Parties' commitments as not addressing anticompetitive effects, but, as noted in detail above, the proper analysis of the Parties' commitments under the Hospital Cooperation Act is whether the benefits accruing from the commitments in their totality outweigh any disadvantages likely to result from a reduction in competition. We emphatically believe they do and submit that the facts demonstrate this.

a. Staff Criticisms Of The Commitments Have No Merit

Staff criticize the Parties' commitments (which staff call "conduct remedies") as "not adequate substitutes for competition" (staff comments at 50) because they would not "maintain competition at the pre-merger level." (*Id*. at 50 n.206) Staff again make misplaced antitrust arguments that lose sight of Tennessee's policy, which is to supplant competition for a regulatory program in which the benefits outweigh the disadvantages from a merger that may be anticompetitive within the meaning of the federal antitrust laws.

Staff opine that the Parties' commitments "are unlikely to be successful in protecting consumers from higher prices and reduced quality." (*Id*. at 51) They offer no evidence of this, and it is not true.[85] Many of the Parties' proposed "conduct" commitments relating to payers are adapted from commitments imposed on the successful Mission Health COPA in North Carolina (*see infra*), and the Parties have added many additional commitments as well – including investing in a Common Clinical IT Platform, creating a Clinical Council to reduce variation, spending significantly on population health, all of which are measurable. These are specific and enforceable commitments.

Staff point to a Massachusetts case that dismissed conduct remedies as insufficient, but that case involved a traditional merger and not a cooperative agreement pursuant to state law that contemplates that disadvantages from decreased competition may occur so long as these disadvantages are sufficiently outweighed by benefits to the community. The merged entity in that case would have been held to compliance before a judge under a judicial consent decree; there was no active state supervision by health department executives in Massachusetts.

[85] A more detailed discussion of why staff's comments regarding the Parties' rate commitments lack merit is in Section III above.

Staff contend it is too difficult to design a compliance mechanism to ensure that the combined hospital system achieves quality targets. Yet they look past a long-term example in Asheville, NC, where the state ably managed Mission Health's COPA for twenty years. In effect, staff argue that the Legislature established a policy that cannot work, and that the Department and Commissioner are unable to do what is needed to make the Cooperative Agreement successful for the region. Both opinions are flatly wrong. The Department has already begun the hard work of identifying the commitments and achievement scoring mechanisms that it thinks are necessary and important to hold the New Health System adequately accountable, and the Parties expect the same diligence by the Commissioner and his staff in their review of our Application and ultimately in the oversight of the Cooperative Agreement.

Staff repeatedly state that the Parties quality commitments do not "appear" sufficient and that it is unclear how the Department can determine achievement of quality commitments. As noted, the commitments contained in the proposed Cooperative Agreement are, to the Parties' knowledge, more extensive than any prior approved cooperative agreements or COPAs, with the potential to go even farther beyond the precedent cooperative agreements and COPAs if more commitments are agreed upon by the Parties, the Department and the Commissioner.

As for accountability, the Parties' proposal in the Application goes much farther than the Mission Health COPA, for example. There, Mission Health submitted only an annual report to the state, and a consultant on behalf of the state analyzed the cost data to determine if Mission Health was in compliance. Staff would apply a standard of accountability not contemplated by the Hospital Cooperation Act and without regard to how the Department and the Commissioner make their final determinations of compliance. As previously mentioned, the Parties have made significant progress with the Department toward making stronger and clearer commitments about achievement can be measured, and they expect this dialogue to continue with the Department and with the Commissioner and his staff during his review of the Application. As the Parties have stated many times, the accountability measures set out in the Application were representative and proposed measures, and made with full expectation that the Department will engage in the meaningful work of ensuring that the New Health System's significant commitments are achieved.

Staff state that the increased publication of quality data committed to by the New Health System is of limited value to consumers due to the end of competition between Wellmont and Mountain States. (staff comments at 61) Their argument is not true. The New Health System will have 75 percent share for inpatient services generally, with 25 percent of the population seeking care at hospitals outside the New Health System. There are other third-party hospitals in Roanoke, Wytheville, Richlands, Asheville, Boone, Pikeville, Winston-Salem, Knoxville and Nashville where patients regularly seek care. The Parties have every incentive to be competitive in the broader region and nationally and have a stated goal of performing in the top decile nationally. As importantly, provision of the quality data holds the Parties accountable. Staff also ignore that the majority of revenue for the New Health System is derived from outpatient services, and these services will continue to be highly competitive.

Staff criticize the Parties' conduct commitments[86] as not doing enough to solve the problem of lost competition. Again, the Tennessee Hospital Cooperation Act contemplates that any benefits from competition that will be lost will be outweighed by benefits to community health in the region. The conduct commitments are yet another part of the overall benefits to flow to Northeast Tennessee that outweigh any likely disadvantages of lost competition. The Parties note that their commitments go beyond those accepted in the successful Mission Health COPA. We also note that Staff ignore that many of our contractual commitments are actions, including designated investments and specific steps regarding implementation of the Common Clinical IT Platform. These are not general reporting requirements, but specific commitments to fund or undertake certain actions that are directly linked to consumer or community benefits.

4. Staff Criticisms Of The Plan Of Separation Are Speculation

Staff claim at pages 63-65 that the Plan of Separation would be an ineffective remedy were the Commissioner to terminate the Cooperative Agreement. At its root, this is merely another irrelevant staff expression of disagreement with the Legislature over the policy virtues of cooperative agreements. Staff point out that "antitrust agencies typically seek to prevent or remedy problematic mergers *before* they are consummated" because it is difficult to "unscramble the eggs" after the merged parties have integrated. (*Id.* at 64; emphasis in original) This is because the antitrust agencies seek to prevent mergers with anticompetitive effects from ever occurring. The Hospital Cooperation Act, in contrast and as discussed above, expressly authorizes approval of a merger with anticompetitive effects in Tennessee that meets the statute's evidentiary standard of a net benefit for the region.

Staff's criticisms of the Plan of Separation also take no account of the fact that the New Health System will be subject to the Commissioner's active and ongoing supervision over the lifetime of the Cooperative Agreement. Under this arrangement, once the merger consummates, the Department will have knowledge about integration actions and will be in a position to evaluate the benefits of that integration at the same time it is monitoring the New Health System's compliance with the terms of the Cooperative Agreement. The Hospital Cooperation Act gives the Department the power to initiate proceedings as needed to ensure compliance and to seek reasonable modifications to a cooperative agreement, with the consent of the Parties, in order to ensure that the Cooperative Agreement continues to meet the requirements of the Act.[87]

Staff list a set of purported deficiencies in the Plan of Separation needed to, in their words, "restore pre-merger competition." (staff comments at 63) Their comments lack merit. As a threshold point, staff misstate the regulatory requirement for the Plan of Separation. The Tennessee Rules and Regulations Governing Cooperative Agreements[88] ("Cooperative Agreement Regulations") establish that a Plan of Separation is a written proposal submitted with

[86]These commitments include not to engage in "most favored nation" pricing with any health plans, not to become the exclusive network provider to any commercial, Medicare Advantage, or managed Medicaid insurer, not to engage in exclusive contracting for physician services (except for certain hospital-based physicians) and not to prohibit independent physicians from participating in health plans and networks of their choice.

[87]Tenn. Code. Ann. § 68-11-1303(f).

[88]Tenn. R. & Regs. § 1200-38-01-.01, *et seq*.

an application to return the parties to a *preconsolidation state*.[89] Staff again insert their own view of what the policy should be, stating that "it would be unrealistic to expect that terminating a cooperative agreement following a merger's consummation would return the hospital system to their pre-merger status." (*Id*.) It is true that markets evolve over time for many reasons, but it will always be possible to divide assets of the merged system to re-create competitive dynamics, should the merger fail to produce continuing public benefits that outweigh anticompetitive effects. Such a determination would be based on a plan submitted to the Commissioner at that time, which would be based on the current reality of the market and the merged system.

It is important to note that, at the request of the Department, the Parties revised the initial Plan of Separation (submitted as Exhibit 15.1 in the Application) to provide additional details to specifically address how the separation would be handled in the first 18 months after closing. This revised Plan of Separation is attached hereto as Exhibit III.B.

5. Staff's Discussion Of COPAs/Cooperative Agreements In Other States Ignores Facts That Undermine Their Arguments

Staff assert at pages 67-70 that cooperative agreements (or COPAs) in other states have experienced "practical problems" and that staff have "some concerns" about them. They reference laws that were repealed in North Carolina, Montana and Minnesota. Here again, staff return to irrelevant policy disagreement with the Legislature and do not address the facts concerning the Parties' Application for a Cooperative Agreement. One of the states that enacted a Hospital Cooperation Act with which staff have concerns is West Virginia, where, as described above, the West Virginia Health Care Department earlier this year rejected virtually the same arguments from staff and approved a Cooperative Agreement for a merger that the FTC challenged on antitrust grounds.[90]

Staff's comment that they are "pleased the North Carolina legislature no longer believes a COPA statute is necessary or beneficial and that problematic hospital mergers would no longer be allowed to proceed under such a statute" is very misleading. North Carolina repealed the law because the Mission Health System that operated under a COPA for the preceding 20 years was successful, because market dynamics had changed, and because the law was no longer needed.[91] Staff fail to point out that Mission Health supported the repeal.

Staff are correct that the Parties point to Mission Health System as an example of a successful COPA. For seven consecutive years Mission Health has been named a Top 100 hospital, and for three consecutive years has been named a top 15 health system in the nation. Under its COPA, quality at Mission Health has been advanced. According to data provided by the State of North Carolina, the costs for health care services at Mission Health have been sustained at a lower level than its peers in the state, and its charges are the third lowest in

[89] Tenn. R. & Regs. § 1200-38-01-.01(14).

[90] *See Morrisey hails FTC decision to withdraw challenge to Huntington hospital merger,* WEST VIRGINIA RECORD (July 7, 2016), *available at* http://wvrecord.com/stories/510955448-morrisey-hails-ftc-decision-to-withdraw-challenge-to-huntington-hospital-merger (accessed October 14, 2016).

[91] See *Legislation Repeals COPA,* MISSION HEALTH, *available a*t http://scope.connectwithmhs.org/content/legislation-repeals-copa (accessed October 14, 2016).

North Carolina despite having the highest Medicare and Medicaid Payer mix in North Carolina.[92] Mission Health has been recognized as one of the nation's best examples of health systems that successfully achieved higher quality while maintaining low costs.[93]

Staff express "skepticism" over Mission Health as a successful COPA. They assert there is "difficulty [in] assessing whether the public policy goals of [that COPA] have actually been met," and cite to three "[i]ndependent health policy experts" who studied but did not reach a conclusion about the Mission Health COPA. (*Id.* at 67) This hardly amounts to evidence that the COPA did not benefit patients, particularly in light of the contrary evidence noted above. Staff selectively cite parts of an Urban Institute report to contend that the results of the merger are uncertain. (*Id.* at 68 n.291) Staff chose not to advise the Department and Commissioner of the following statements from that study:

- "Both Medicare and private payer per-person costs have been found to be low in Asheville, while quality is good, according to independent findings using different data. Indeed, well-recognized policy experts have held up Asheville as one of the best communities for providing high value hospital care."
- "Policymakers should consider quasi-regulatory oversight of provider consolidation like that of the Mission COPA because antitrust oversight has done little to prevent, roll back or continually discipline consolidation and its high prices for consumers."[94]

It is true the Urban Institute poses several reasoned questions about the complex nature of COPAs and leaves them open for ongoing public policy debate. But Tennessee resolved its public policy in 2015. Its policy is one that promotes the approval of cooperative agreements for health care transactions in Tennessee that meet the statutory standard.

The "difficulties" staff perceive in determining whether Mission Health was a successful COPA and the "skepticism" they place on evidence that it was a success stand in stark contrast to the certainty staff express in their advocacy against a Cooperative Agreement in Tennessee, particularly in light of the absence of substantial facts that supports their position. The simple fact is that staff have never conducted a comprehensive study of the Mission Health COPA, its effects on pricing, quality and efficiency, and staff, therefore, have no evidence to point to which refutes the very successful results of Mission Health in the last 20 years. Absent such evidence, and given the accolades Mission Health has received for quality, lower cost and high value, it is wholly inappropriate to discard such results. This is particularly true given the similarity in the primary markets of Sullivan/Washington Counties in Tennessee and Buncombe County, North Carolina.

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[92] *See Regulation vs. Ability to Compete: What is the Certificate of Public Advantage?*, MISSION HOSPITAL SCOPE (May 6, 2011), *available at* http://www.mission-health.org/sites/default/files/document-library/1710_0.pdf (accessed October 14, 2016).

[93] *See Mission One of ten Hospitals Named for "Doing It Right*," MISSION HOSPITAL SCOPE (August 7, 2009), *available at* http://www.mission-health.org/sites/default/files/document-library/1292_0..pdf (accessed October 14, 2016).

[94] See Randall R. Bovbjerg & Robert A. Berenson, *Certificates of Public Advantage: Can They Address Provider Market Power?,* URBAN INSTITUTE, at 22 (2015), *available at* http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf (accessed October 14, 2016).

Importantly, while staff have expressed a lack of concern for out of market mergers of the type Wellmont and/or Mountain States may need to pursue absent a Cooperative Agreement, they should consider some relevant facts about the market in North Carolina that are also informative for the Department in making its decision. First, in the 20 years Mission Health operated under a COPA, neither the FTC nor the Justice Department has accused Mission Health of unlawful behavior or behavior harmful to consumers. In fact, according to the Urban Institute, insurers have claimed that the behavior of Mission Health in negotiating contracts has been no different than other systems in North Carolina.[95] This suggests the COPA was effective at governing the behavior of Mission Health. Second, the only health system in North Carolina which has recently been accused of anti-competitive behavior by the Justice Department is Carolinas Health System.[96] This system formed over time through out-of-market mergers and acquisitions. The North Carolina system the federal government has seen fit to accuse of anti-competitive behavior is not the one formed under a COPA, but rather, one formed in the manner with which staff seem to have no concerns with respect to future transactions with our local health systems. Without any evidence to suggest Mission Health or any other system formed under a COPA has behaved in a manner to harm consumers, the Parties are left to assume all staff have done is to speculate.

The Carolinas example demonstrates another important point overlooked by staff. Should the Cooperative Agreement terminate and the New Health System no longer be under state supervision with immunity under the antitrust laws, then it will be fully subject to suit under any of those laws. Anticompetitive behavior by the New Health System in a post-Cooperative Agreement situation could be challenged by the FTC, the Department of Justice (as in the Carolinas example), state Attorneys General, and private citizens.

Staff also discuss Benefis Health in Montana, the COPA for which was terminated in 2007. (staff comments at 68-69) Staff refer to a blog site that purports to report price increases that followed repeal of the COPA statute in Montana. (*Id.* at 69 n.297) Staff provide no evidence that these alleged price increases were anticompetitive; indeed, the increases could have been market corrections following a period of overly aggressive price constraints under the COPA. In this case, this would be evidence that the COPA did, in fact, provide consumers with a benefit not enjoyed by consumers elsewhere in the state where pricing was even higher. The same blog post quotes a University of Montana professor (Larry White), who said "Benefis actually had some of the very lowest unit costs in the state of Montana for various kinds of medical services."[97] Staff did not provide that quote in their comments. Staff also did not provide the following quote concerning Benefis Health post-COPA charges: "Benefis' charges are 16 percent lower than . . . Montana peers for inpatient and outpatient care combined, according to the most recent data from the Montana Hospital Association."[98] If this is true, then even after the COPA was repealed and prices increased, the prices remained 16 percent below

[95]Bovbjerg & Berenson.

[96]*See Impact of antitrust suit against CHS could ripple nationwide,* CHARLOTTE OBSERVER (June 12, 2016), *available at* http://www.charlotteobserver.com/news/local/article83142307.html.

[97]Jimmy Tobias, *Costly Care, MISSOULA NEWS* (March 26, 2014), *available at*http://missoulanews.bigskypress.com/IndyBlog/archives/2014/03/26/great-falls-hospital-merger-holds-lessons-for-missoula.

[98]Tobias.

peer hospitals. The article shared by staff provided no validated data from which to draw any conclusions. Nor, to the Parties' knowledge, has Benefis been accused of any anticompetitive behavior harmful to consumers by any federal or state agency.

E. Conclusion

Staff's application of traditional merger analysis to the cooperative agreement framework established by the Legislature is incorrect. The Hospital Cooperation Act sets forth Tennessee's policy to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the Department in order to facilitate the provision of quality, cost-efficient medical care to rural patients. The Parties' Application and the commitments made therein satisfy the standards of the Hospital Cooperation Act and demonstrate that the significant benefits to the people of Tennessee will outweigh any anticompetitive effects of the merger. Staff's misplaced analysis along with the unsubstantiated claims and inaccuracies contained in their submission lead to the conclusion that the Department should disregard and reject the assertions of staff's submission.

IV. RESPONSE BY APPLICANTS

TO SUBMISSION OF

AMERIGROUP TENNESSEE INC.

Amerigroup's overlapping arguments with those of FTC staff begin on page one of the Amerigroup comments. Like staff, Amerigroup takes issue with the sovereign policy that underlies the Hospital Cooperation Act (the "Hospital Cooperation Act" or the "Act").[1] The Tennessee Legislature (the "Legislature") passed this law in 1993 and overwhelmingly reaffirmed it only *nineteen months ago*, stating:

> "It is the policy of this state, in certain instances, *to displace competition* among hospitals with regulation to the extent set forth in this part and to actively supervise that regulation to the fullest extent required by law, *in order to promote cooperation and coordination among hospitals in the provision of health services* and to provide state action immunity from federal and state antitrust law to the fullest extent possible to those hospitals issued a certificate of public advantage under this section."[2]

Amerigroup opines "that there are numerous reasons why [Certificates of Public Advantage] are a poor substitute for competition" and offers "five reasons" in support of this view that FTC Chairwoman Ramirez has previously espoused. (Amerigroup comments at 1) The policy prerogatives of Amerigroup, the FTC Chairwoman and staff, however, are not relevant in this proceeding. Tennessee's sovereign policy is to promote health care mergers – even mergers that may be anticompetitive within the meaning of federal and state antitrust laws – where the benefits outweigh the disadvantages resulting from the loss of competition between the merging parties.

Amerigroup does not, just as staff does not, acknowledge the hard facts about the very difficult health and economic conditions facing the citizens of the mostly rural region of Northeast Tennessee. Amerigroup conducts business in this region, making its silence in this regard even less understandable than that of the Washington, D.C.-based staff. It is therefore not surprising that Amerigroup, like staff, cannot show how the status quo that each endorses better serves Northeast Tennesseans or offers a better solution to the problems in the region than the Cooperative Agreement outlined in the Parties' Application.[3]

The Parties find irony in Amerigroup's opposition to this sovereign Tennessee policy, given that it conducts its business in Tennessee under much the same construct. The State limits the number of health plans that may offer its products in the TennCare market, such that

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[1] When it unanimously reaffirmed the Hospital Cooperation Act of 1993, the State of Tennessee clearly articulated and affirmatively expressed a policy to improve the welfare of Northeast Tennesseans by encouraging integration among healthcare providers, even in anticompetitive transactions, if the overall net effect is to facilitate better care:

> It is the policy of this state, in certain instances, to displace competition among hospitals with regulation to the extent set forth in this part and to actively supervise that regulation to the fullest extent required by law, *in order to promote cooperation and coordination among hospitals in the provision of health services* and to provide state action immunity from federal and state antitrust law to the fullest extent possible to those hospitals issued a certificate of public advantage under this section. (emphasis added).

Tenn. Code Ann. § 68-11-1303, *et seq*. (effective May 18, 2015) [hereinafter the "*Hospital Cooperation Act*"].

[2] Hospital Cooperation Act (emphasis added).

[3] Amerigroup, the only payer that submitted comments into the Tennessee record opposing the merger, accounts only for approximately 3 percent of claims and 2 percent of charges at Wellmont, and 3.7 percent of claims and 3.5 percent of charges at Mountain States.

consumers have limited choices and providers have few choices, or no choices, in determining whether to contract with Amerigroup, and under what conditions. Amerigroup benefits from this policy, and despite weakness in its own plan (for instance, Amerigroup is the only health plan the Parties are aware of which does not have its own provider network), faces no threat to competitive entry in its space once it has been deemed by the State to be a protected health plan in a region. The State permits Amerigroup to offer its product and actively supervises Amerigroup through a contract, presumably because the State has determined it is in the interest of the State and public to limit competition in favor of efficiency and management of the program.

The remainder of Amerigroup's Introduction is a summary of points made later in the Amerigroup comments. The Parties respond to those points in the sections that follow.

A. Response To Amerigroup Discussion Of "The Loss Of Competition From The Merger"

In this section, Amerigroup presents the same antitrust arguments found in the Staff Submission, relying on statistics calculated from draw area shares and concentration, and evaluating the merger using the analytical steps set forth in the FTC-Department of Justice Horizontal Merger Guidelines (the "Merger Guidelines"). (Amerigroup comments at 7-11)[4] As the Parties noted about staff's virtually identical structural antitrust analysis, the discussion of market shares and concentration merely informs the Department that staff, or in this case Amerigroup, believes the merger is anticompetitive under Section 7 of the Clayton Act. The structural analysis does not address whether the merger meets the different balancing test and evidentiary standards of the Hospital Cooperation Act.[5]

Amerigroup speculates and misunderstands the law in stating that Mountain States' proposed acquisition of Laughlin Memorial Hospital and Wellmont's proposed acquisition of Takoma Regional Hospital "is evidence that the Parties plan to expand their dominant position in the market by acquiring independent hospitals," and that "[i]f the Department grants this COPA there would be nothing to prevent the New Health System from purchasing additional providers and expanding even further—something that is not prohibited by the proposed COPA." (Amerigroup comments at 9) Laughlin Memorial Hospital and Takoma Regional Hospital are examples of hospitals that reside in a county contemplated as part of the Geographic Service Area and under the regulatory scope of the COPA if it is granted. Moreover, while the Parties have no plans for expansion of the New Health System through acquisition, any out-of-market acquisitions would not eliminate competition. Amerigroup's comments are without merit.

[4] In addition to the Merger Guidelines, Amerigroup relies in this section on a letter from the FTC's Director of Policy Planning, staff's (rejected) comments to the West Virginia Healthcare Authority ("WVHCA") regarding a cooperative agreement application before that body, and an economic paper by Michael Doane and Luke Froeb. (Amerigroup comments at 9-11 & notes 26-39) In their Response to the Staff Submission, the Parties describe WVHCA's instructive reasoning in rejecting staff's comments and approving the cooperative agreement filed by two competing hospitals. *Response to FTC Staff Submission* at 9-12. The Parties also point out the unrealistic conclusions and significant economic flaws contained in the Doane and Froeb paper. *Response to FTC Staff Submission* at 20, n. 45.

[5] *Response to FTC Staff Submission* at 4-6.

B. Response To Amerigroup Claim That Benefits Are "Illusory And Unsubstantiated"

Amerigroup argues that the Department "should focus principally on merger-specific benefits – those that could only be obtained absent the merger and not through an alternative means that are less restrictive to competition" – because, Amerigroup continues, "according to the statute one of the disadvantages to be weighed against the potential benefits is "the availability of arrangements that are less restrictive to competition." (Amerigroup comments at 12, citing Tenn. Code Ann. § 68-11-1303(e)(3)(D)).Amerigroup neglected to quote the full provision, which goes on to state " . . . 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."[6] This omission is consistent with Amerigroup's pattern of either ignoring or grossly undervaluing the benefits to be obtained by the merger.

Amerigroup has not identified a single alternative arrangement that would meet this standard. The Department must evaluate this factor along with many others in making the determination whether the transaction's benefits outweigh the disadvantages caused by the loss of competition between the merging parties.[7]

As the Parties previously described, in this respect, the Hospital Cooperation Act is very different from how the FTC assesses a merger's efficiencies (or benefits) under the Merger Guidelines.[8] Amerigroup's claim that the two frameworks are "substantially similar" is flatly wrong. (Amerigroup comments at 12) The reason for the difference is that the FTC assesses mergers only for their effect on *competition*. The Hospital Cooperation Act, in contrast, creates a pathway for qualified mergers *even if they may be anticompetitive*. The FTC gives no credit whatsoever in a merger antitrust analysis to efficiencies that are not merger-specific.[9] The Hospital Cooperation Act requires only that the availability of other transactions that would generate the same benefits be considered as a factor among others in an overall balancing of benefits versus disadvantages. The FTC evaluates efficiencies only insofar as they enhance the merged firm's "ability and incentive to compete" and to the extent they "reverse the merger's potential harm."[10] It will refrain from challenging an otherwise anticompetitive merger only if the efficiencies "are of a character and magnitude such that the merger is *not likely to be anticompetitive* in any relevant market."[11] None of these concepts are embedded in the Hospital Cooperation Act.

Amerigroup's arguments also fail to heed the core principles of state-action immunity. As the Supreme Court recently stated:

> The Sherman Act serves to promote robust competition, which in turn empowers the States and provides their citizens with opportunities to pursue their own and

[6]Tenn. Code Ann. § 68-11-1303(e)(3)(D) (2016).

[7]Tenn. Code Ann. § 68-11-1303(e) (2016).

[8]R*esponse to the Staff Submission* at 4-6.

[9]*Merger Guidelines* at § 10.

[10]*Merger Guidelines* at § 10.

[11]*Merger Guidelines* at § 10.

the public's welfare. *The States, however, when acting in their respective realm, need not adhere in all contexts to a model of unfettered competition.* While "the States regulate their economies in many ways not inconsistent with the antitrust laws," in some spheres they impose restrictions on occupations, confer exclusive or shared rights to dominate a market, or otherwise limit competition to achieve public objectives. *If every duly enacted state law or policy were required to conform to the mandates of the Sherman Act, thus promoting competition at the expense of other values a State may deem fundamental, federal antitrust law would impose an impermissible burden on the States' power to regulate.*

For these reasons, the Court in *Parker v. Brown* interpreted the federal antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity. That ruling recognized Congress' purpose to respect the federal balance and to "*embody in the Sherman Act the federalism principle that the States possess a significant measure of sovereignty under our Constitution*." *Since 1943, the Court has reaffirmed the importance of Parker's central holding*.[12]

Amerigroup**,** like staff, tries to promote its own policy preference over that of the Legislature and to shoehorn antitrust law enforcement concepts into the evaluation of cooperative agreements. They are completely different frameworks, and Amerigroup's arguments fail.[13]

[12]*North Carolina State Bd. of Dental Examiners v. FTC*, 135 U.S. 1101, 1109 (2015) (citations omitted)(emphasis added).

[13]A recent Federal Trade Commissioner herself recognized that the agency does not possess sufficient information to opine on non-competition-related public policy goals of state laws that restrict competition. In a January 8, 2016, dissent to an FTC and Dept. of Justice joint statement on repeal of the South Carolina Certificate of Need statute, then-Commissioner Julie Brill states:

"My concern is I do not believe the Agencies possess sufficient relevant information to opine on noncompetition-related public policy goals of the CON laws. Our experience is broad but it does not extend to every issue. The FTC should advise South Carolina policy makers based on our area of expertise—competition—and not overstep our collective knowledge. Health care policy makers at the state level are faced with difficult issues separate and apart from the strong benefits competition brings to health care markets. These include the critically important issue of preserving access to care for the needy, and doing so in a complex market, involving informational asymmetries among patients, providers, and payors. In this context, it is important to understand that competition will not move resources from those that can afford health care to those that cannot. As the Agencies stated in 2004:

'competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payors. Competition also will not shift resources to those who do not have them.'"

The Staff's comments are an example of the agency's representatives "overstepping their collective knowledge" and clearly lack merit in this proceeding. Former Commissioner Brill's full statement can be found at https://www.ftc.gov/system/files/documents/public_statements/905323/160111ftc-doj-sclawstatement.pdf?utm_source=govdelivery (citation omitted).

1. Response To Amerigroup Claim That The Proposed Benefits Do Not Reflect Significant Investments Different From What They Are Doing Currently

In questioning the Parties' specific commitments totaling $450 million, Amerigroup quotes language from the Application that the merger is motivated in large part by "the important and increased need for investment in population health, management of information and measurable improvement in cost and quality, combined with the continued downward pressure on reimbursement from government and commercial payers." (Amerigroup comments at 13, quoting Application at 1) Amerigroup does not challenge the "important and increased need for investment in population health, management of information and measurable improvement in cost and quality" and the other stated motivations for the merger. Instead, Amerigroup attempts to belittle the Parties' specific commitments totaling $450 million for various important programs needed in the region, arguing that despite this "soaring language," the Parties are already making investments which could total over $450 million over ten years.[14]

In response to Amerigroup's criticisms, the Parties have expressly stated that the $450 million commitment is **incremental**, specifically that the "investments are intended to be incremental and constitute additions to current spending costs."[15] As the Application states, funding the population health, access to care, enhanced health services and commitments would be impossible without the efficiencies and savings created by the merger. (Application at 57, *see* Amerigroup comments at 13)[16] The Department can and will monitor and enforce the Parties' commitment of this $450 million incremental investment to provide additional important health care services in the region.

The Parties' specific commitments are based on review of the Tennessee State Health Plan and the regional collaborative health improvement goals such as those set forth in Healthier Tennessee, and extensive feedback received over many months from the people the Parties serve across the region—direct feedback from hundreds of people ranging from regional leaders to health care consumers, including feedback from the four Community Health Work Groups. That feedback revealed strong support for local governance and control because local governance and control works hand-in-hand with local input. These commitments, shaped by local input, address the unique needs and goals of this region because they are developed by local people who live, work, and raise families in this region. The commitments provide solutions to address an epidemic of behavioral health and addiction problems with new resources to help turn the tide of

[14]Amerigroup does not dispute the importance of these programs and identifies the programs to include expanding mental health, addiction recovery and substance abuse prevention programs; developing and growing academic and research opportunities supporting post-graduate health care training; developing programs for children's health and preserving and expanding rural services and access points. (Amerigroup comments at 14-15) Importantly, Amerigroup also concedes that some of the Parties' commitments, if met "could offer substantial value to northeast Tennessee and southwest Virginia." (Amerigroup comments at 21)

[15]*See Responses to Questions Submitted April 22, 2016 by Tennessee Department of Health in Connection with Application for Certificate of Public Advantage,* at Exhibit. 20 (July 13, 2016) [hereinafter "*July 13 Department Responses*"], *available at* http://tn.gov/assets/entities/health/attachments/WHS-MSHA_April_22,_2016_DOH_Response_1.pdf.

[16]Importantly, the Amerigroup comments shows the extent to which these two local hospital systems are already making substantial expenditures to improve health care in the region, based on the Parties' first-hand knowledge of the needs of this region. It is unlikely that any out-of-market acquirer would be willing to continue this level of funding. Further, the Amerigroup comments assumes that the hospital systems will be able to continue their current level of funding if they remain independent, but given the documented financial pressures, there is no assurance this level of funding will continue.

poor community health and chronic disease, invest in services not currently available, and create economic opportunity through academics and research.

In addition, since the Application was deemed complete by the Department, the Parties have proposed revised and broadened commitments to the Southwest Virginia Health Authority and have presented these revised commitments to the Department for consideration (the "Revised Commitments"). Revised Commitments also include more specific ways in which achievement of those commitments can best be demonstrated and measured on an ongoing basis.[17]

Coming from an organization based outside the area, Amerigroup's criticism that local control and governance is only "a nice sound bite" (Amerigroup comments at 4) is both dismissive of and disrespectful to the people of the region and to the local government entities that have expressed their support, made it clear that local solutions are needed to solve the serious challenges facing the region, and invested significant effort in identifying those challenges and formulating proposed solutions. Beyond seeking profit from the State's taxpayers through the TennCare program under a regulatory system which protects Amerigroup from "unfettered competition" in the open market, the Parties are unaware of a single effort by Amerigroup or its parent to invest time, resources or effort into addressing these critical issues in the region. Conversely, these issues are top of mind to the local governance of the health systems based in the region. Therefore, local governance is not merely a "sound bite." It is uniformly a relevant and critical issue to the political and business leadership of the entire region – a fact consistently revealed for the record through multiple public hearings and comments by business and political leaders since announcement of the proposed merger.

2. Response To Amerigroup Claim That The Benefits Could Be Achieved Without The Merger

Building upon its mistaken and uninformed argument that the investments "may reflect nothing little more than the Parties' current activities" (Amerigroup comments at 16), Amerigroup argues that out-of-market acquisitions may provide similar benefits to the region.[18] Amerigroup provides no basis for this speculation other than to cite self-serving press releases posted by the out-of-market acquirers. Importantly, even a cursory review of these releases demonstrates that they do not involve areas with similar characteristics to this region. Specifically, the out-of-market mergers cited do not involve rural regions with high poverty rates, higher rates of serious health problems, very high percentages of Medicare, Medicaid, Medicare managed care and uninsured patients, a declining population, a small and shrinking base of commercial patients and rural hospitals with very low patient volumes requiring substantial financial investment to ensure that important services remain available in smaller rural communities.

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[17] SOUTHWEST VIRGINIA HEALTH AUTHORITY, *Proposed Revised Commitments*, [hereinafter "*Revised Commitments*"] *available at* https://swvahealthauthority.net/commitments/.

[18] As the Parties pointed out in the *Response to the Staff Submission*, the West Virginia Health Care Authority ("WVHCA") recently rejected a similar argument when it approved a cooperative agreement between two West Virginia hospitals under a law very similar to the Tennessee Hospital Cooperation Act. The WVHCA held that it was unwilling to jeopardize important programs for the region based on speculation that another purchaser may offer similar programs. *See* In Re: Cabell Huntington Hospital, Inc., Cooperative Agreement No. 16-2/3-001 (W. Va. June 22, 2016).

For example, Amerigroup references Novant building a 60-bed hospital in Prince William County in Northern Virginia, a much more affluent and growing area than the Southwest Virginia and Northeast Tennessee area.[19] In fact, the press release cited states the hospital will serve the "growing" northern Virginia community. As pointed out in the Application, many of the Parties' hospitals in Southwest Virginia have an average daily census of less than 30 patients with significant excess capacity and a declining area population, while the rural hospitals in Northeast Tennessee have an average census ranging from 1 to 30.[20] Similarly, the other examples involve situations where new hospitals and facilities were being built to serve growing demand, not situations where out-of-market acquirers were committing to maintain low occupancy or struggling rural hospitals in areas with high poverty and serious health challenges.

Further, since Amerigroup references the Novant acquisition of Prince William Health System, which occurred in 2009, it may prove educational to review the publicly available data regarding the outcome of this out-of-market acquisition. From the date of acquisition in 2009 through 2012, the hospital consumer price index increased by a compounded annual growth rate ("CAGR") of 3.4 percent.[21] According to the publicly filed hospital cost report data over that same time period, the Novant-acquired hospital's case mix index remained flat, but Gross Revenue per Adjusted Admission grew by a CAGR of 8 percent, or 30 percent over three years. Net Revenue per Adjusted Admission grew by a compounded annual growth rate of 7 percent. This revenue growth per adjusted admission was in excess of expense growth of 3.5 percent CAGR. This revenue growth per adjusted admission is roughly twice the growth of the hospital Consumer Price Index. While the specific pricing at Prince William Medical Center is not available, it is clear that, on a case-mix adjusted, volume adjusted basis, gross revenue per adjusted admission increased dramatically after the acquisition. Generally, gross revenue per adjusted admission relates to gross charges, while net revenue per adjusted admission relates to collections on a per-unit basis. Adjusted for case mix, there appears to be no other explanation for such dramatic increases in volume adjusted revenue other than *pricing increases*. The Parties are not aware of publicly available data to suggest substantial improvements in quality, cost, or patient satisfaction. The Parties believe that this type of "out-of-market" acquisition is not what is best for the region and this data underscores why the Parties believe there is greater value in the proposed merger than turning the Parties' hospital assets over to an outside system, as Amerigroup would have the Parties do.

Amerigroup also argues that the Parties could achieve some of the proposed efficiencies and benefits without merging (Amerigroup comments at 18) but offers no examples of

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[19] A news release from this entity states that the population of western Prince William County is projected to grow more than 20 percent over a two-year period. Prince William Health System, *Prince William Health System Completes Merger with Novant Health to Expand Quality Health Care in Northern Virginia,* PR NEWSWIRE (July 1, 2009), *available at* http://www.prnewswire.com/news-releases/prince-william-health-system-completes-merger-with-novant-health-to-expand-quality-health-care-in-northern-virginia-62090857.html.

[20] Amerigroup also cites to Novant "steering" members to a UVA hospital, but it is unclear whether members were being steered to an out-of-market hospital. (Amerigroup comments at 17) Here, the Parties intend to provide needed services locally, including specialty services.

[21] *See Novant Health UVA Health System Prince William Medical Center Profile*, AMERICAN HOSPITAL DIRECTORY, *available at*: https://www.ahd.com/free_profile.php?hcfa_id=98bd57eed13c350c01e783b9186db671&

ek=6f27bcb739d76b93b4326cdfc35ad934.

collaborations that would not be challenged under the antitrust laws and/or involve a very complicated and costly antitrust compliance infrastructure. Such alternative collaborations would very likely require, among other things, sharing of confidential and competitively sensitive cost and price information between competitors along with agreements regarding the services each system will offer and not offer, the direction of referrals, which facilities to keep open, close, downsize or repurpose and the number, type and the compensation of specialists and subspecialists. The cost-savings potential is much smaller without full integration, leaving the Parties with fewer and probably insufficient resources with which to fund the ongoing capital and operating needs of the hospitals, much less the proposed new spending by the Parties for the public benefits.

In fact, many of the Parties' rural hospitals were previously owned by not-for-profit or for-profit systems. For a variety of reasons, each of these hospitals chose to become part of either Mountain States or Wellmont. These reasons included, among others, downward pricing pressure, reduced utilization of services, and lack of growth leading the boards or corporations to conclude the hospitals could not thrive in the market. In some cases, the hospitals were part of large multi-state or regional hospital systems. And in other cases, the hospitals went through multiple owners before being acquired by either Mountain States or Wellmont. The conditions leading to these divestitures and partnerships, in fact, have worsened. Without the commitments contained in the Application by the New Health System to keep these hospitals open, the reality exists that many of the hospitals in Northeast Tennessee and Southwest Virginia would struggle to survive. Tellingly, Tennessee has had the second-highest number of hospital closures in the nation since 2010 at eight.[22]

Finally, Amerigroup asserts that Covenant Health System "continues to express interest" in partnering but provides no support. (Amerigroup comments at 4) Amerigroup is not aware of the proposals of the various health systems to acquire Wellmont or Mountain States and is not aware of the potential financial and other implications of such proposals. Amerigroup's comment about Covenant is uninformed and irrelevant.

C. Response To Amerigroup Claim That Commitments Offered By The Parties Are Not A Replacement For Competition And Will Not Adequately Protect Patients Against Competitive Harm

Amerigroup claims that the commitments will not assure that the Cooperative Agreement will result in the claimed benefits. (Amerigroup comments at 5) This assertion is false.

As discussed above**,** the legislative intent of the Hospital Cooperation Act is to create a pathway for approval of hospital mergers that might be seen as anticompetitive, if they qualify under the statute's balancing test for benefits versus disadvantages. To ensure that the balance of net benefits is maintained in keeping with state policy, the Act, including the regulations accompanying the Act, provides that the COPA shall be governed by terms of certification that

[22]Ayla Ellison, *A state-by-state breakdown of 80 rural hospital closures*, BECKER'S HOSPITAL REVIEW (Dec. 13, 2016), *available at* http://www.beckershospitalreview.com/finance/a-state-by-state-breakdown-of-80-rural-hospital-closures.html.

include "conditions of reporting and operations determined by the Department to demonstrate Public Advantage."[23]

Instead of evaluating the commitments on whether they mirror the results of competition, the Department must evaluate whether the benefits of the Cooperative Agreement outweigh the potential disadvantages in consideration of Tennessee's stated goal to "further improvements in the quality of health care for Tennessee citizens, moderate increases in cost, improve access to needed services in rural areas of Tennessee and enhance the likelihood that smaller hospitals in Tennessee will remain open in service to their communities."[24]

The Parties have made commitments in the Application to address the benefits listed in the COPA Regulations by which the State will measure the success of the Cooperative Agreement.[25] The Parties' substantial, comprehensive commitments address fundamental health issues and priorities in Northeast Tennessee that compel the need for highly integrated and organized solutions led by the New Health System in close collaboration with community leaders and under the direct, active supervision of the State.[26] The commitments made by the Parties create mechanisms such as rate restrictions to ensure reasonable prices, conduct restrictions to ensure non-exclusionary practices, commitments from the Parties to pursue high quality performance, and significant other commitments to invest money from merger-generated cost savings into programs that will improve population health, expand access to care, and create community benefits tailored specifically to the needs of Northeast Tennessee's rural patients. Active and ongoing supervision of these commitments will be performed by the State, as set forth in the Hospital Cooperation Act, to ensure the New Health System's compliance with the policy goals articulated by the Tennessee General Assembly.[27]

The Parties do not dispute that they should be held to commitments that are both meaningful and enforceable. The commitments are the mechanisms by which the Parties will mitigate the disadvantages, if any, from elimination of the areas of competition, and improve quality of health care and access to health care in this rural region. In fact, the Parties proposed specific accountability mechanisms in their Application to enforce each commitment.[28]

To ensure that the commitments are enforceable, the Parties have also proposed that the New Health System be held to an overall standard each year under the Overall Achievement Scoring mechanism. The Parties anticipate that the Overall Achievement Score would be calculated annually and would be used by the State to objectively track the progress of the Cooperative Agreement over time to ensure the merger results in public advantage. If the New Health System fails to achieve an agreed upon passing score in any year, the State may invoke its

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[23]Tennessee's regulations implementing the Hospital Cooperation Act, Tenn. Comp. R. & Regs. § 1200-38-01-.03 [hereinafter "*COPA Regulations*"]. The Parties have made numerous commitments in the Application to ensure the Cooperative Agreement results in and demonstrates public advantage.

[24]Hospital Cooperation Act of 1993, Tennessee Laws Pub. Ch. 331 (1993).

[25]Tenn. Comp. R. & Regs. § 1200-38-01-.03(2)(a).

[26]See Application Table 11.12 at 110-114 for a summary of the Parties' 30 commitments.

[27]Tenn. Code Ann. § 28-11-1303; Tenn. Comp. R. & Regs. § 1200-38-01-.06.

[28]See Application Table 11.12 at 110-114 for a summary of the Parties' 30 commitments, including accountability mechanisms.

authority to seek modifications to the Cooperative Agreement or to begin regulatory action up to and including to revocation of the Cooperative Agreement.[29]

1. Overall Achievement Scoring

The "Overall Achievement Scoring" system proposed in the Application was intended to be a proposal for the two states to consider. Ultimately, the states will determine the active supervision mechanism that is required to ensure the continuing public advantage of the Cooperative Agreement as required by the Hospital Cooperation Act and Regulations.

The Parties have been engaged in productive dialogue with the Department regarding specific measures, weighting of measures, scoring of measures, and the overall scoring system. (See *Response to FTC Staff Submission* at 43-44) The discussions with the Department are ongoing as of this date. The Department's review of the Parties' proposed Cooperative Agreement has been, and continues to be, thorough and focused on the health care needs of the region it serves. The Parties anticipate that the Department may have additional input as the review process continues on the specific focus of the commitments and how achievement of these commitments should be substantiated.

2. Rate Commitments[30]

Amerigroup criticizes the Parties' rate commitments on the grounds that "[s]ubstituting price regulation for market-based competition among providers is rarely done because it is almost impossible to do." (Amerigroup comments at 24) This is wrong on two grounds. First, this criticism is aimed at the State's policy to supplant competition with a regulatory program for qualified health care transactions in Tennessee. Amerigroup's policy objection is not relevant to the Department in its consideration of the Parties' Application.

Second, Amerigroup's criticism is wrong because the Parties' rate commitments are not "regulation" in the sense that Tennessee would be tasked with affirmatively setting rates. The Parties have agreed to two distinct rate commitments. In the first, for all Principal Payers, the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System" ("Rate Reduction Commitment"). In the second commitment, the Parties will not increase negotiated rates by more than a fixed index rate for both existing and prospective Principal Payer contracts. For negotiated hospital rates, this cap is the hospital Consumer Price Index (CPI) minus 0.25%. For physician and outpatient service rates negotiated by the New Health System, the cap is medical care CPI minus 0.25% (collectively, the "Rate Cap Commitment"). [31]

Amerigroup makes much of the fact that "there are only a few examples of hospital mergers being granted an exemption from antitrust scrutiny under the state action

[29]Tenn. Comp. R. & Regs. §§ 1200-38-01-.06, 1200-38-01-.07.

[30]Many of Amerigroup's comments regarding rate commitments overlap with comments by staff. Accordingly, the Parties incorporate by reference herein the Parties' *Response to Staff Submission* Section III, which relates to the rate commitments.

[31]These commitments reflect revisions that Parties have recommended be incorporated into the Tennessee COPA. *See Response to Staff Submission* at 17-21.

doctrine." (Amerigroup comments at 24) This argument is meaningless. One of those examples occurred this year in West Virginia. It is an example of the dynamic responses recently taken by many states to worsening health and economic conditions, including those in Tennessee, Virginia (Cooperative Agreement law passed in 2015) and New York (Certificate of Public Advantage law passed in 2011). Amerigroup does not identify a single application for a Cooperative Agreement or Certificate of Public Advantage for a hospital merger rejected by any state. Not surprisingly, Amerigroup also does not come forward with any argument or evidence that the twenty-year Mission Health Certificate of Public Advantage in North Carolina led to supra-competitive prices or sub-competitive quality. Indeed, the facts show otherwise.[32]

Without supplying evidence, Amerigroup says the approach North Carolina led to "distortions in the market." (Amerigroup comments at 25) Amerigroup's contention that even an effective rate cap may be evaded by shifting services from one category to another, or by dramatically changing utilization patterns at facilities, thereby permitting higher than anticipated revenues, is inapplicable to the pricing caps proposed by the Parties. Amerigroup apparently is unaware that the economists engaged to evaluate specific forms of regulation in North Carolina expressly supported the implementation of price caps for inpatient and outpatient services that are very similar to those in the Parties' commitments. Those economists explained ways in which simpler rate cap regulation applied to specific services address alleged "distortions." (*See* Response to Staff Submission at section III.B.1).

Moreover, the Parties' proposed rate caps will apply to both inpatient and outpatient services, thereby eliminating the alleged risk of evasion or incentive to evade. Caps apply to physician services as well. Further, any attempted major changes away from current customary and usual contract terms that would permit such alleged substantial changes in utilization would be immediately detectable by payers and readily reported to the Department as part of the active supervision function.

Further, as Amerigroup should know, payer contracts contain many terms and conditions that greatly minimize if not eliminate the "gaming" that Amerigroup alleges. This is particularly the case for a health system subject to binding commitments and active state supervision. Any attempt to evade the rate commitments or re-write them without justification related to incumbent contract provisions that protect the payer would be easily identified by both the payer and the state supervising officials. Where, for example, contracts involve terms for inpatient care at fixed rates per DRG regardless of length of stay or services utilized (i.e., a fixed price for a particular diagnosis) and a similar system for outpatient care, the provider is at risk for managing length of stay. Amerigroup suggests in its comments that that the New Health System may over-utilize services or extend hospital stays without clinical justification (Amerigroup comments at 26); however, existing provisions limit economic incentives for such actions.

[32] *See Response to Staff Submission* at 46-48. *See* Randall R. Bovbjerg and Robert A. Berenson, Certificates of Public Advantage, Can they Address Provider Market Power?, URBAN INSTITUTE, at VI (February 2015), *available at* http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf. which states in part:

> "Both Medicare and private payer per-person costs have been found to be low in Asheville, while quality is good, according to independent findings using different data. Indeed, well-recognized policy experts have held up Asheville as one of the best communities for providing high value hospital care."

Moreover, with regard to the other means that Amerigroup suggests, there are, for example, "circuit breaker" provisions that effectively prevent rate increases above a certain level.

Amerigroup contends the rate cap will operate as a price floor rather than a cap. (Amerigroup comments at 26) This is not correct. It ignores the commercial realities of contract negotiations when both payer and the New Health System will be informed with data and information about their current contract as well as the Consumer Price Index ("CPI") and rate cap. It also ignores that the rate cap, being tied to the hospital CPI (for hospital rates) and the Medical CPI (for physician rates), ties the rate increases to industry-level increases driven by widely accepted inputs for costs as determined by the United States Bureau of Labor Statistics. This ensures rate increases reflect actual industry experience in cost increases, which protects against increases in excess of what would otherwise have resulted from increased market concentration without such regulation.

The rate cap is also considerably below any levels that would appear likely to raise concerns about price increases. To support its claim that the proposed rate cap will act as a floor, Amerigroup relies on a single contracting example from outside Tennessee, where Amerigroup says Anthem obtained rates below the proposed cap. (Amerigroup comments at 25-26) This assertion is misleading on several grounds. First, it is backward-looking and misses the point of the proposed rate cap. The cap's purpose is not to maintain past pricing levels, but rather to prevent future prices from increasing at rates of change that are substantially above would have been achieved with competition. The proposed rate cap constrains price increases to be lower than the hospital CPI and the Medical CPI, demonstrating that pricing increases will be at a rate below the industry norms. Further, Amerigroup ignores the commitment which will reduce rate inflators by 50 percent in the second full year after completion of the merger. This reduction resets the rate of increase for rates even prior to implementing the annual cap in rate increases. Thus, it is accurate to say that pricing will be generally lower with the merger than it would have been without the merger.

Second, Amerigroup conspicuously ignores Anthem's significant market and bargaining power. Anthem has a dominant share of more than 80 percent in the commercial market embracing the Virginia communities to be served by the New Health System (which will rise to exceed 90 percent if Anthem's proposed merger with Cigna, under antitrust challenge by the Department of Justice, is consummated). This gives Anthem substantial market power to impose favorable rates and certainly not to fall victim to rates by a health system subject to a limiting cap and active supervision. For other commercial payers that lack Anthem's dominant position, the proposed rate cap represents a significant achievement that will provide immediate benefit to their enrollees. Moreover, even for Anthem, the proposed rate cap provides increased predictability of cost changes to Anthem for a portion of its covered population across the years, thereby providing greater ability to establish premiums and relevant targets.

Moreover, the cap will be a cap – even if it is a floor, the floor is also the ceiling, and rate increases will be constrained to reflect measures of overall cost changes based on neutral benchmarks that in recent history have been small percentage changes. Amerigroup and the New Health System have aligned incentives to achieve improved quality and value, and thereby reduce costs – and to seek contractual terms that will achieve improved outcomes as well as cost reduction. Where the Parties are constrained to keep rate increases across the scope of their

health care activities consistent with CPI rates that are anticipated to change at only a low rate, the Parties have every incentive to align quality and cost of care with payer's incentives to manage these for their enrollees.

Amerigroup criticizes the exclusion of non-"Principal Payers" from the rate cap commitment, contending that it should apply to all commercial payers, regardless of how much they contribute to the New Health System's net revenue. (Amerigroup comments at 25) Although Amerigroup trumpets the "substantial" number of payers implicated by this threshold, the raw number vastly overstates the local significance of the payers in question. Collectively, the roughly 200 payers that individually provide less than 2 percent of net revenue together account for less than 3 percent of the New Health System's total net revenue. From a business perspective, application of the proposed rate cap to such de minimis payers could risk net losses to New Health System. [33] Further, it is in the interest of the New Health System to ensure multiple payers compete in the market, and the New Health System will be likely to encourage entry by payers with a stable history and high quality. The New Health System should not, however, be compelled to assume the business risk of advantageous pricing to new entrants or existing payers which have a poor history of operation, poor patient satisfaction, poor provider relationships or a poor network of providers from which consumers can choose.

Amerigroup also complains that the proposed rate cap commitments exclude certain government insurance programs, contending that commitments offered in Virginia with respect to Medicaid managed care, TRICARE and Medicare Advantage plans differ from commitments offered in Tennessee. (Amerigroup comments at 25) The Parties have, as noted, amended the rate cap commitment in Virginia to extend to negotiated government plan contracts including managed Medicaid, TRICARE and Medicare Advantage plans, and the Parties have offered this same revised commitment to the Department for consideration.

Amerigroup's comments on risk-based contracting models are misleading and inaccurate on several counts. First, Amerigroup flatly dismisses, with no reasonable justification, the Parties' commitment to discuss risk-based models with its Principal Payers. Second, Amerigroup weakly attempts to refute the Parties' specific statements about a distinct form of risk contracting with vague generalities about "risk-based arrangements" Amerigroup has allegedly entered into in unidentified "nearby" regions. Third, Amerigroup draws inappropriate and inaccurate conclusions about Mountain States' capacity to engage in risk based models from the example of the AnewCare Accountable Care Organization.

"Risk-based" contracting models exist on a spectrum. The Parties understand risk-based models to mean a financial and clinical arrangement between a payer and provider(s) where a substantial portion of the financial risk related to the medical spending for the care of the patients over time has been assumed by the provider(s). This definition understands "risk-based" models to encompass both upside and downside risk.

The Parties' commitment to discuss such risk-based models with willing payers is a meaningful and substantial commitment. It demonstrates the Parties' willingness to consider and

[33] Even very small changes in the risk profile of payers with very small numbers of enrollees could cause relative costs to change very substantially.

enter into true risk arrangements that entail not only upside risk (i.e., the potential for shared savings) but downside risk as well. Amerigroup offers no definition of "risk-based" models and, as a result, its criticisms of the Parties' commitment are vague, inaccurate, and, ultimately, meaningless.

Amerigroup first attacks the Parties' assertion that "no payer has historically expressed an interest in a global spending cap for hospital services in the region." Amerigroup then insinuates that its own supposed interest in exploring "risk-based models" somehow disproves the Parties' statement. The Parties stand by their assertion, and in fact state emphatically that Amerigroup has not provided any evidence of such global spending cap contracts it has entered. In the Parties' experience payers operating in the region have approached these kinds of risk-based models (i.e., global spending caps) with caution. Amerigroup's vague statement about its own contracts not only fails to contradict the Parties' statement, it highlights the point that "risk-based models" encompass a broad spectrum of contracting possibilities.

Amerigroup wrongly claims that Mountain States' experience with the Accountable Care Organization AnewCare shows that Mountain States can already engage in risk-based models without need of a merger. Here, again, Amerigroup's failure to define "risk-based" models distorts the facts and results in misleading claims. Mountain States has indeed developed the AnewCare Accountable Care Organization. It has also worked in good faith with willing payers to explore risk-based models as a standalone system. Mountain States has even concluded contracts with a few payers that include some risk-based elements. But these examples fail to support Amerigroup's claim about Mountain States' ability to act alone; in fact, they show the reverse. The proper lesson to take from the AnewCare example is that, acting alone Mountain States is incapable of assuming significant downside risk, and will not do so without a meaningful critical mass of lives in the market. In fact, Mountain States has already attempted to pursue such a risk-based model with downside risk through its offering of a Medicare Advantage Plan, Crestpoint Health. Crestpoint Health was closed in 2016 due in large part to its inability to generate enough critical mass of lives. Wellmont, as a competitor to Mountain States, did not contract as a provider, thus limiting the ability of Crestpoint to achieve the lives necessary for assumption of full risk.

There is no one-size-fits-all risk-based model appropriate for all payers and providers. The Parties' risk-contracting commitment recognizes this reality. It commits the Parties to pursuing true risk-based contracting models, while recognizing that different payers will approach this concept according to their own interests and goals. The Parties recognize they cannot force a specific, pre- defined risk-based model on any payer.

Amerigroup also criticizes a proposed commitment concerning "most favored nation" ("MFN") pricing and exclusivity. The Parties are committed to this provision. The Parties also recognize that compliance with the sizeable commitments relies upon achieving synergies in the market. Further, the Parties have pointed to ongoing competition that will exist in the market for outpatient services. In the event Certificate of Need ("CON") regulation is repealed, and new market entry occurs, it is possible that with the increase in competition, some of the conduct commitments may no longer be beneficial to the State. While Amerigroup is incorrect in asserting that these MFN and exclusive contracting conduct commitments are conditioned on the continued existence of CON regulation in Tennessee, the Parties do believe that such a material

event affecting the operations of the New Health System could be adverse to the expenditure commitments and thus, be of interest to the State.

3. Service Commitments

Amerigroup claims that the service commitments are incomplete and lack any details regarding specific plans, timelines or the costs to achieve them. (Amerigroup comments at 6) The Parties address both of Amerigroup's claims individually below.

Amerigroup Claim about Commitment #1: Amerigroup claims the commitment that "[a]ll hospitals in operation at the effective date of the merger will remain in operation as clinical and healthcare institutions for at least five [(5)] years" is too vague to be meaningful. (Amerigroup comments at 28)

Response: As noted above, the Parties have presented Revised Commitments to the Southwest Virginia Health Authority and have offered the same Revised Commitments to the Department for consideration. In the Revised Commitments, the Parties agreed to define "essential services" for purposes of this commitment as:

- Emergency room stabilization for patients;
- Emergent obstetrical care;
- Outpatient diagnostics needed to support emergency stabilization of patients;
- Rotating clinic or telemedicine access to specialty care consultants as needed in the community and based on physician availability;
- Helicopter or high acuity transport to tertiary care centers;
- Mobile health services for preventive screenings, such as mammography, cardiovascular and other screenings;
- Primary care services;
- Access to a behavioral health network of services through a coordinated system of care; and
- Community-based education, prevention and disease management services for prioritized programs of emphasis based on goals established in collaboration with the Commonwealth and the Authority.[34]

The Parties believe this proposed definition of "essential services" provides clarity for the minimum levels of service availabilities that the Parties are committing to post-combination for this five-year period.

Amerigroup Claim about Commitment #2: Amerigroup claims the Parties' commitment to adopt a Common Clinical IT Platform as soon as reasonably practical is too vague. Amerigroup further claims that Wellmont's participation in the OnePartner HIE makes the Parties' commitment to participate meaningfully in an HIE open to community providers a benefit that is not merger-specific. (Amerigroup comments at 29)

[34] *Proposed Revised Commitments.*

Response: The Parties direct Amerigroup to the detailed timetable for implementation of the new Common Clinical IT Platform in their July 13 Department Responses.[35] Amerigroup also fails to note that neither Wellmont nor Mountain States is a full participant in OnePartner and even if they were, that would not replicate the functionality of a single, integrated electronic health record system.

Amerigroup fails to recognize the difference between a Common Clinical IT Platform and an HIE. As noted in the July 13 Department Responses, the Common Clinical IT Platform is designed to facilitate the sharing of electronic health information across the New Health System, while the HIE will allow the New Health System to share electronic health information with participating providers across the region and nation - regardless of their affiliation with the New Health System.[36]

Providers across the Geographic Service Area use a variety of EHR systems that may not be able to share data with the New Health System. The HIE is a way of sharing electronic health information among doctors' offices, hospitals, labs, radiology centers, outpatient centers, and other health organizations. While the OnePartner HIE system is useful in reaching out to independent physicians, the current system is limited in the data that it can transmit.[37] There is significantly more functionality for a provider utilizing a Common Clinical IT Platform, including order entry, pharmaceutical management and clinical patient management, among many other functions, which are not the core purpose of an HIE.[38]

The investment in a Common Clinical IT Platform is essential to creating a "One Patient, One Record" approach that allows all clinicians practicing within the New Health System to effectively evaluate a patient's clinical profile and to make decisions that support high quality care without duplication of clinical resources. Better communication of patient data and best practices via a thriving regional HIE will also improve patient care and lower cost of care.

4. Quality Reporting Commitments

Amerigroup attacks the quality reporting commitments as too vague, apparently conceding that such commitments would have value if more clearly defined.[39] (Amerigroup comments at 29-30) In the July 13 Department Responses, the Parties set out additional detail related to the potential benefits and disadvantages that form the basis for the quality reporting commitments.[40]

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[35] *July 13 Department Responses,* Exhibit 17.

[36] *July 13 Department Responses,* Exhibit 10, 19.

[37] See *July 13 Department Responses,* Exhibit 10 for a detailed description of the Parties' plans for the EHR system, a description of the plan to convert to a single records system, and the expected features, the benefits of the Common Clinical IT Platform, and the expected benefits of the Common Clinical IT Platform to the Regional Health Information Exchange.

[38] *July 13 Department Responses,* Exhibit 10.

[39] In this regard, Amerigroup recognizes that the exchange of health information across a common IT platform "is a benefit." (Amerigroup comments at 29)

[40] *July 13 Department Responses,* Exhibit 10.

5. Physician Commitments

With respect to physician commitments, Amerigroup lists a number of commitments made by the Parties which it does not challenge. (Amerigroup comments at 30-31)[41] Amerigroup then argues that there are inappropriate concentration levels in certain physician specialty areas, but lists only five of the twenty-three specialty areas identified by the Parties. (Amerigroup comments at 31)[42] Notably, Amerigroup does not mention that it is referencing only a very few categories out of the twenty-three physician specialties serving the area that happen to have shares where 60% or a lower percentage of physicians are independent. Nor does it mention that these categories account for only a small proportion of the total physicians in the area. In fact, a very large number of physicians in the area are independent, and there are several specialties in which there is no overlap between the Parties (in terms of employed physicians) and the majority are in categories where independents' shares are high (and the Parties' share is commensurately low).

Of the five specialty areas selected by Amerigroup, two are hospitalists and urgent care physicians who, because of the nature of their practice, would not be competing for ongoing patient relationships as their interaction with patients is based on facility use. Even in these categories, there are a large number of independent physicians in the area – 146 hospitalists and 38 urgent care physicians. By referencing only the share numbers, Amerigroup suggests that there are limited alternatives, which these numbers show otherwise. Similarly, for the other three categories, which include more highly specialized physicians, these also have a number of independent physicians (50 cardiovascular, 39 pulmonology, and 19 hematology/oncology physicians in addition to those employed or affiliated with the Parties). In sum, of the remaining eighteen categories of specialists, they are made up mostly of independent specialists and half of the categories show no overlap between Mountain States and Wellmont.

Amerigroup also speculates, without foundation, that despite the Parties' commitment not to materially increase the percentage of physicians employed or affiliated with the New Health System, this may still happen, especially with respect to high-level specialties. (Amerigroup comments at 32) Amerigroup ignores the specific statement by the Parties that the physician employment model will only be used to facilitate bringing **needed** specialties to rural or underserved areas or when private physician groups do not want to expand or do not exist.[43] Amerigroup's objection is misguided in a region currently deprived of needed specialties. The Parties also expressly state in their submissions that their objective is to support the independent practice of medicine.[44] Amerigroup also acknowledges that the use of caps on physician

[41] These commitments described by Amerigroup include maintaining open medical staffs, not engaging in exclusive contracting for physician services (other than hospital-based physicians), not requiring exclusivity by physicians practicing at the new system's hospitals, and not inhibiting independent physicians from participating in health plans and health networks of choice.

[42] *See Responses to Questions Submitted May 27, 2016 by Southwest Virginia Health Authority in Connection with Application for Letter Authorizing Cooperative Agreement*, at Replacement Exhibit 14.1 (Section E) (July 13, 2016) [hereinafter "*July 13 Authority Responses*"] , *available at* https://swvahealthauthority.files.wordpress.com/2016/07/msha-responses-to-questions-bates.pdf.

[43] *July 13 Authority Responses* at 46.

[44] *July 13 Authority Responses* at 46.

numbers is not always effective.[45] This is an important notation because of the national trend of physicians to seek employment with health systems or large physician groups. While it is not the desire of the New Health System to grow their numbers of employed physicians, the New Health System must be able to attract and retain high quality physicians in specialties that require employment.

6. Plan Of Separation

Amerigroup's brief complaint about the Plan of Separation fails to recognize that the Department will have active and ongoing supervision over the New Health System over the lifetime of the Cooperative Agreement. The Department will therefore have knowledge about integration actions and be in a position to evaluate the benefits of that integration as it monitors the New Health System's compliance with the terms of the Cooperative Agreement. It is true that markets evolve over time for many reasons, but it will always be possible to divide assets of the merged system to re-create competitive dynamics, should the merger fail to produce continuing public benefits that outweigh anticompetitive effects. Such a determination would be based on a plan submitted to the Commissioner at that time, which would be based on the current reality of the market and the merged system.

[45] *See* Amerigroup comments at 32.

V. RESPONSE BY APPLICANTS

TO SUBMISSION OF

PROFESSORS AND ACADEMIC ECONOMISTS

This section responds to comments by several professor and academic economists urging the Department to reject the Application, and to instead "encourage" the Parties to seek alternative yet unspecified arrangements. Like the other critics, the Academics fail to acknowledge the critical health care needs of the region, challenges to the long-term financial sustainability and stability of health care delivery and the express policy of the State of Tennessee to approve cooperative agreements in order to improve health care, moderate cost increases, improve access in rural areas and enhance the likelihood that smaller hospitals will remain open. In fact, the Academics appear not to have reviewed in any detail the extensive Application and subsequent submissions filed by the Parties that address these objectives, nor do they acknowledge the extensive community support for the merger.[1]

Importantly, the Academics' comments provide no guidance relevant in the context of the State of Tennessee's important public policy objectives expressed in the Hospital Cooperation Act, which governs the Application. Under the COPA process, and through ongoing active supervision by the State, rate regulation and contractual commitments can directly mitigate any potential market power effects, and specific enforceable commitments can assure substantial benefits to the region.[2] Moreover, the COPA context is uniquely relevant for mergers where continued competition by two independent competitors does not provide benefits that are as sustainable or as substantial as a merger reviewed and approved by the State with specific commitments that the State actively supervises.[3] The Academics' analysis totally fails to address the State's public policy objectives to supplant competition with regulation for mergers and should therefore not be accorded any weight. Significantly, nowhere do the Academics challenge the need for the specific commitments by the Parties, which the savings from the merger will fund, that will directly benefit health care in the region.

The Academics' comments assume, without any factual inquiry into this specific merger, that the elimination of "head-to-head" competition between the Parties would result in substantial harm to consumers and communities, and most importantly, that forcing the continuation of such "head-to-head" competition by blocking this merger would result in significantly more efficient, effective and high-value delivery of care and consumer and community benefits than the care that the New Health System will provide as a result of this merger under the COPA. The Academics' comments provide no basis other than general academic studies to assert that continued competition would yield greater consumer and pro-competitive benefits in this particular case. The Academics' comments do not appreciate the

[1]The Academics do not state their experience and qualifications to comment on state-supervised and approved mergers involving health care entities and the public policy benefits of such state-approved and supervised mergers. Moreover, conspicuously absent from the Academics' comments is any reference to or evaluation of net benefits of COPA arrangements, including the literature that recognizes the benefits of the Mission Health COPA.

[2]A COPA is further distinguished from settlements and consent decrees, such as those referred to by the Academics' comments by, among other factors, the role of a regulator such as the Department, which actively supervises the merger and has substantial knowledge about the health care needs of the region, in contrast to a court.

[3]Market conditions such as declining admissions, financial pressures due to reduced or low reimbursements for Medicaid or Medicare patients and significant excess capacity can result in higher operating costs per patient or poor financial performance of individual facilities or of systems. They can also create less-than-optimal scale services. Competition may make reduction or elimination of excess capacity difficult, while mergers and consolidation may permit it. For a discussion of the economics of excess capacity, *see, e.g.,* Kathleen Carey, *Stochastic Demand for Hospitals and Optimizing "Excess" Bed Capacity*, 14 J. REG. ECON. 165 (1998); Esther Gal-Or, *Excessive Investment in Hospital Capacities*, 3 J. ECON. & MGMT. STRATEGY 53 (1994).

impact that significant projected declines in reimbursements and in inpatient admissions due to expected population and patient trends and shifts to other care locations will have on hospital operations and costs. They also do not comment on the urgent need to reduce health care costs in this region by, along with other efforts, reducing avoidable admissions and emergency department utilization.

The Academics' comments fail to account for critical drivers of medical costs and expenditures in this region, which include significant underlying health needs and suboptimal management of health care delivery and risk. They do not address the imperatives to align incentives and care delivery and to make substantial investments in specific programs to improve health care, like the investments that efficiencies from the proposed merger will fund. These investments and merger-specific changes in health care delivery are necessary to support a financially sustainable, high-quality care delivery system in the region. Simply put, the Academics' comments appear to assume that the current system of service duplication and limited investment in the substantial health care needs of the region is preferable to reduction of duplication, investment of the $450 million in resulting efficiencies, and price caps to regulate pricing. They do not address the financial ramifications or instability caused by two large health systems operating side-by-side with duplicative services, heavy debt obligations and numerous rural facilities with low utilization.

The Academics' comments state that hospital mergers of direct competitors are likely to result in anticompetitively higher prices and that there is limited evidence supporting any likely cost efficiencies or benefits from such mergers. They also assert that integrated delivery systems and most forms of coordination involving hospitals, including ACOs, are unlikely to yield benefits. The Academics conclude that price and other commitments in regulatory arrangements or consent decrees are complex and unenforceable.[4]

These opinions are predicated largely on general academic literature or reference to unrelated litigated or settled cases. The assertions are neither fact-based nor informed by detailed examination of this proposed merger, the local communities and conditions in which these health systems operate or the challenges facing the Parties and their communities if the merger does not proceed. The Academics' comments seem to assert that competition between two organizations always yields better outcomes for consumers and communities than a merger—regardless of specific marketplace conditions, hospital financial and cost conditions or underlying

[4]The Academics' comments reject the idea that a shift from fragmented and independent care delivery to an integrated delivery system, such as an ACO, is likely to result in reduced costs or achieve benefits. "The recent performance of Accountable Care Organizations ('ACOs'), alliances formed to bear risk for medical spending of Medicare enrollees, provides another data point with regard to the ability of provider organizations to reduce health care spending and maintain and improve quality. The Centers for Medicare and Medicaid Services ('CMS') reported in 2014 that slightly less than half of ACOs participating in the Medicare Shared Savings Program achieved savings relative to the CMS benchmark – about what one would expect from a random sample of health care delivery organizations. More recently, a study in the New England Journal of Medicine found that savings generated under ACO models were small at best, and that savings were consistently greater in independent primary care groups than in vertically-integrated hospital-provider groups." (Academic comments at 5) (internal citations omitted). However, ACOs do not approach the same level of substantial integration as this proposed merger, and this merger is not vertical, so the comparison is inapposite. This quote from the Academics' comments also illustrates the reliance on "average" (Academic comments at 1) or irrelevant comparisons and overlooks that even within their cited studies there are specific examples of significant benefit, especially between independent groups. The Academics' comments appear to discount or reject any "mixed" or inconsistent results as informative of the prospect of benefits from a specific combination.

demographics and health conditions. They discount substantially benefits of health system–driven realignment involving elimination of duplicative services, merger-specific efficiencies, reinvestment of efficiency savings to promote health care in the region and price caps that limit rate increases.[5]

The Parties respond to the Academics' comments as follows:

A. Competitive Effects and Pricing: The Academics' comments state the proposed merger should be rejected based on selected survey papers that review academic studies evaluating hospital merger price effects.[6] While the cited survey papers, such as Town and Vogt (2006) and Gaynor and Town (2012), emphasize findings suggesting significant price effects from hospital consolidation, these same academic survey papers also include academic studies that find no significant price increases from hospital mergers or increased concentration and statistically significant decreases in prices in post-merger retrospective studies.[7] The Academics' comments

[5]This viewpoint stands in contrast to health care and economic literature on the benefits of integrated delivery systems and the reality of extensive ongoing realignment and transformative change in health care. The Affordable Care Act has accelerated such change, but the change is independent of the law and is driven by efforts to align incentives and control around closely integrated and coordinated care by health systems trying to address dramatically changed demand conditions with facilities and assets designed for past demands. While there are many models of integrated health delivery, an especially important model involves merger and alignment of hospitals and their integration with other providers. For a review of integrated delivery systems, see Anthony Shih, *et. al*, COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM, THE COMMONWEALTH FUND, *Organizing the U.S. Health Care Delivery System for High Performance* 4-8 (August 2008). The Commonwealth Fund also commissioned studies of 15 different integrated systems, and the results highlight the diversity of organizational arrangements accomplishing re-alignment of health care and the importance of health-system led initiatives. Douglas McCarthy & Kimberly Mueller, *Organizing the U.S. Health Care Delivery System for High Performance* (July 2009). For a review of more health-system led initiatives in integrated care delivery with population health, see David B. Nash, *Improving Population Health by Working with Communities*, 9:5 AM. HEALTH & DRUG BENEFITS 257 (2016); David B. Nash, *Population health: where's the beef?* 18:1 POPULATION HEALTH MGMT. 1-3 (2015); and David B. Nash, *The population health mandate: A broader approach to care delivery*, 23:1 BOARD-ROOM PRESS 3-8 (2012).

[6]The Academics' comments assert: "An extensive body of economic literature finds that hospital mergers among close competitors lead to higher prices, on average, while evidence of cost savings and quality improvements is scant." (Academic comments at 1) (emphasis added) (internal citations omitted). In support of the statement that this effect occurs "on average", the Academics' comments cite two survey papers that review and summarize results of studies on horizontal effects. *Id.* (*citing* Martin Gaynor & Robert J. Town, ROBERT WOOD JOHNSON FOUND.: THE SYNTHESIS PROJECT, *The Impact of Hospital Consolidation—Update* (2012), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; William B. Vogt & Robert J. Town, ROBERT WOOD JOHNSON FOUND.: THE SYNTHESIS PROJECT, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, Policy Brief no. 9, at 11 (2006), *available at* http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html). The Academics also reference Leemore Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52(3) J. LAW & ECON. 523-550 (August 2009) (which is included in the 2012 review); *and* M. G. Vita & S. Sacher, *The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study*. The Academics' comments do not reference many of the caveats associated with the referenced studies, including those by the authors. The Dafny article, for example, cautions against "extrapolating the results" of the empirical evaluation to hospital mergers in general. Moreover, the Academics' comments do not note that the Gaynor-Town and Vogt-Town articles include examples of merger studies that show no systematic statistical relationship between concentration and price and a retrospective study that shows statistically significant price decreases.

[7]The two survey papers cover a range of empirical studies of hospital mergers or price-concentration studies and generally find mixed results and no systematic relationship between price and consolidation. For example, with regard to merger retrospectives, the results do not support a consistent finding of higher prices from all mergers (even accepting the methodologies by which estimated price effects are derived, which have been criticized). Some retrospectives show statistically significant price decreases, including a study of a merger in a highly concentrated market investigated by the FTC, which closed its investigation. *See* STATEMENT OF THE FEDERAL TRADE COMMISSION, F.T.C. File No. 011 0225, *Victory Memorial Hospital/Provena St. Therese Medical Center* (2004), *available at* http://www.ftc.gov/sites/default/files/documents/closing_letters/vista-health-acquisition-provena-st.therese-medical-center/040630ftcstatement0110225.pdf. For two retrospective studies, including one with significant price decreases, see Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18:1 INT'L J. ECON. & BUS. 17-32 (2011). Studies of price concentration examined in these survey papers also do not

do not reference the findings of these latter papers, even though they appear in the same survey papers that the Academics rely on. The Department should have a more complete and balanced view of the cited academic literature in order to put the Academics' comments in perspective. It should also be noted that the conclusions drawn in the cited academic literature are mixed, and only about "average" or general findings, not about a specific merger or this specific merger, analysis of which would require a detailed, fact-intensive and individual inquiry.

B. Merger Benefits Including Efficiencies: The Academics' comments also state that there is little, if any, empirical evidence of cost-savings or benefits from hospital mergers and use this purported lack of evidence to support rejection of the proposed merger.[8] Any alleged difficulty in academic research regarding clear findings about efficiencies or quality does not mean that individual hospital mergers—including the proposed merger—will not provide significant consumer and community benefits. The Academics' comments do, in fact, note that a major empirical study demonstrated "substantial" cost savings from horizontal hospital mergers (Academic comments at 4), but they fail to state that the cited study examined mergers of the same type as the proposed merger: in-market mergers with planned consolidation of clinical services and other cost-saving approaches.[9]

The Academics' comments also fail to reference more recent articles identifying benefits from hospital mergers,[10] which include an article co-authored by the Academics' comments' lead author, Leemore Dafny, discussing the attributes of "good" mergers and listing several examples of "cognizable" efficiencies as benefits from mergers.[11] These include several efficiencies similar to those that the Parties have identified as likely to result from the proposed merger and documented for the Department.[12] The Dafny-Lee article on "good" mergers also describes the importance of health care leaders' actions in shaping change and efficiencies:

> A "good" merger or affiliation is one that increases the value of health care by reducing costs, improving outcomes, or both, thereby enabling providers to generate and respond to competition. Although regulators can sometimes stop a "bad" merger, they cannot create a good one. Which type of merger predominates as consolidation proceeds will depend on the

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show systematic increases in prices. *See, e.g.*, Asako S. Moriya, et. al, *Hospital Prices and Market Structure in the Hospital and Insurance Industries*, 5:4 HEALTH ECON., POLICY & LAW 459-479 (2010) (one of the reviewed studies which does not find a statistically significant relationship). For a summary of related studies, see also Margaret E. Guerin-Calvert, *Competitive Effects Analyses of Hospital Mergers: Are We Keeping Pace with Dynamic Healthcare Markets*?, ANTITRUST BULLETIN (2014).

[8] David Dranove & Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22:6 J. HEALTH ECON. 983-97 (2003).

[9] *Id.*

[10] *See, e.g.*, Toby Singer, et. al, *The Pro-Competitive Benefits of Hospital Mergers*, HOSPITALS AND HEALTH NETWORKS DAILY (Sept. 25, 2012), *available at* http://www.hhnmag.com/articles/5212-the-pro-competitive-benefits-of-hospital-mergers.

[11] The authors note "clear specification of cognizable efficiencies with explicit accountability for achievement is a key input to a "good merger." Leemore S. Dafny & Thomas H. Lee, *The Good Merger*, 372 NEW ENG. J. MED., 2077-79 (May 28, 2015), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1502338.

[12] *Id.*

> actions of the leaders of our health care institutions. The decisions they make will have enormous influence on the ability of our health care system to deliver on its promises. (Footnotes omitted)[13]

The article's finding indicate that the health system's leadership, coupled with identification of community health care needs and undertaking and implementing detailed planning, are fundamental steps for community and consumer benefits. The leadership at Wellmont and Mountain States has taken these steps, and the commitments in the Application provide for accountability and measurement by the Department.

C. Inconsistency of the Academics' Comments with Merger Enforcement: The Academics' comments are conceptual and general, not tied to evaluation of any individual merger evaluation. The most compelling evidence that the Academics' comments' selective and literature-based concerns overstate the risks of anticompetitive price increases from horizontal mergers is their inconsistency with the enforcement landscape. The vast majority of hospital mergers reviewed by the federal antitrust agencies are approved, including many involving hospitals in concentrated markets.[14] In fact, only a small portion of hospital mergers that receive intensive antitrust scrutiny are challenged.[15] A recent empirical review of FTC second request transactions, which include those receiving intensive scrutiny, demonstrated that the majority of hospital mergers with second requests were approved, and many appear to have involved efficiency benefits.[16]

D. Rate Caps, Commitments, and Regulation: Rate caps and related contractual commitments substantially mitigate concerns about anticompetitive pricing in this proposed merger. The Academics' comments challenge whether the proposed rate cap methodology can emulate the effect of competition and keep rates of price growth reasonable. They claim that rate regulation and caps are susceptible to regulatory evasion and not adaptable to changes in health care payment models or to entities (e.g., payers) that are newly contracting with the Parties. They assert further that the

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[13]The authors go on to articulate the importance of accountability and public commitments: "Higher-value health care will not result from good intentions alone; translating this ideal into reality takes vision, planning, and resolve. . . . Making these goals explicit not only helps stakeholders and regulators to assess the merits of a proposed deal, but it also creates public commitments that can facilitate the execution of those plans after the merger occurs." *Id*.

[14]Table 4, Darren Tucker, *A Survey of Evidence Leading to Second Requests at the FTC*, 78 ANTITRUST L.J. 591 (2013).

[15]According to a former Chairman of the FTC, less than 2 percent of all reviewed mergers were challenged, and many transactions subject to intensive scrutiny were not challenged. *See* Jon Leibowitz, Chairman, Fed. Trade Comm'n, Remarks at the Antitrust in Healthcare Conference, *Are Titanic Health Care Costs Sinking Us? What the FTC is Doing to Keep Patients Afloat* (May 3, 2012), *available at* http://www.ftc.gov/speeches/leibowitz/120503antitrusthealthcare.pdf ("Let me pause here lest you get the impression that we never see a hospital merger we like. These are rough numbers, but according to public sources, 2007 to 2011 witnessed approximately 333 hospital mergers nationwide. About one third of those, approximately 111, were reported to the FTC under Hart-Scott-Rodino. Of those, approximately one tenth triggered Second Requests. We challenged only four in court – less than two percent of all hospital mergers over the last five years.")

[16]*See* Table 4, Darren Tucker, *A Survey of Evidence Leading to Second Requests at the FTC*, 78 ANTITRUST L.J. 591 (2013).; *see also* Margaret E. Guerin-Calvert & Jen Maki, CTR. HEALTHCARE ECON. & POLICY, "Hospital Realignment: Mergers Offer Significant Patient and Community Benefits" (2014), *available at* http://www.fticonsulting.com/~/media/Files/us-files/insights/reports/hospital-realignment-mergers-offer-significant-patient-and-community-benefits.pdf.

Parties' commitments are complex and not enforceable.[17] These comments are addressed elsewhere in the Parties responses in more detail. The Academics' views on the workability and value of the form of rate caps and the commitments appear to be general or based on selected consent decrees. They are inconsistent with economists' reports on preferred forms of rate caps in other COPA contexts that address the types of regulatory evasion and complexity raised by the Academics' comments.[18] They do not appear to be based on any systematic review of the specific commitments that the Parties have made. The Academics' comments also ignore the important benefits to employers and payers of low and predictable rates of price growth.

For these reasons, the Department should not give any weight to the Academics' comments in its consideration of the proposed merger and its expected benefits. The Academics do not dispute that the region suffers from significant health care needs that are not currently being adequately addressed and that require more effective use of resources. The merger offers cost savings, efficiencies and investments in needed facilities, including specific enforceable commitments totaling $450 million over ten years, to respond to these needs in accordance with the State of Tennessee's express objectives as stated in the Hospital Cooperation Act. The Academics offer no specific alternatives that would provide similar benefits to an area with these significant health care needs.[19]

[17]For example, the Academics' comments note: "We are also concerned about the enforceability of the Applicants' commitments. These concerns have both conceptual and practical bases. As an example of the former, consider the Applicants' promises to fund community investments through cost reductions. Assessing whether post-merger cost reductions are in fact being used for this purpose requires well-accepted, relevant, and comprehensive measures of cost. However, such measures do not exist." (Academic comments at 6). This is incorrect. It is not necessary for the Department to have cost measures in order to verify that the Parties have honored commitments to expend certain dollar amounts of commitments on specific programs. There are clear commitments and accountability measures, and no need to link each expenditure and commitment back to comprehensive cost measures. Questions and concerns regarding the Partners consent decree, including the court's opinion in that case about enforceability of commitments, are inapt. That matter involved a consent decree and not a COPA and did not involve application of a state public policy objective to displace competition with mergers that provide substantial benefits to a region with significant needs. The proposed rate caps were much more complex in that case, as were the commitments. In this case, the funding commitments are readily observable and enforceable, as is the rate cap.

[18]Cory S. Capps, "Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health System, A Review of the Analysis of Dr. Greg Vistnes, with Additional Recommendations for Lessening Opportunities for Regulatory Evasion by Mission Health," at Section III (May 2011); Greg Vistnes, "An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health," 18-19 (February 10, 2011).

[19]The Academics also raise concerns about the difficulty in measuring performance and the ability of the Department to monitor performance. (Academic comments at 2) In this regard, the Academics ignore the various submissions by the Parties on performance measurement and the actual oversight and supervision that the Department will conduct.

VI. RESPONSE BY APPLICANTS

TO SUBMISSION OF

KENNETH KIZER, M.D., MPH, AND

A. Introduction.

Dr. Kizer's "Independent Assessment" of the proposed merger consists merely of unsupported opinions and citations with little relevance to the proposed merger, representing another attempt by staff to generate opposition from individuals who are neither qualified as experts to comment on local health economic conditions or have chosen to ignore the critical health care needs of the area. Dr. Kizer simply recites staff's unfounded opinions without any facts in support, cites broad studies pulled from public sources such as the internet that have no application to the specific circumstances of the proposed merger, and speculates about the merger, but offers little independent assessment. Unlike other experts who have opined in favor of the merger,[1] Dr. Kizer has never even spoken with the Parties about the Application. Dr. Kizer admits he has conducted only a limited review of information relevant to the Parties' proposal, focusing mostly on the one-sided staff "draft" submission to the Department and staff's submission in Virginia. Dr. Kizer's comments make only limited reference to the detailed submissions made by the Parties, which specifically describe the programs the Parties will initiate if the merger is approved, including $450 million in increased spending to benefit the region.

Like staff and other critics, Dr. Kizer does not comment on the potential harm an out-of-market acquisition would pose to the region in the way of higher pricing, elimination of services or hospitals, or loss of local governance. He does not comment on the impact that population stagnation combined with reduced inpatient utilization will have, particularly given the region has the second lowest Area Wage Index in the nation (and thus, among the lowest Medicare and Medicaid Reimbursement rates). And he does not comment on how the combination of these factors with an out-of-market entity absorbing at least $1.4 billion in debt will affect the acquiring entity's pricing models. With decreased projected utilization, substantial cost of duplication and downward pressure on Medicare and Medicaid rates, remarkably, Dr. Kizer does not comment on the need of an acquiring system to create incremental new revenue to deal with these market realities. Ignoring these facts does not make them go away.

Instead of dealing with these financial and utilization facts, Dr. Kizer focuses on alternatives which involve loose affiliations. He references these loose affiliations but does not substantiate any savings he suggests they might generate. In fact, no independent study provides evidence these affiliations have generated even a fraction of the synergies equivalent to the $450 million that the merger will generate and reinvest in the community or the $110 million in annual savings. Had Dr. Kizer reviewed more of the extensive information that the Applicants provided to the State, he would have at least been able to measure the independently validated savings the proposed merger will generate against the imagined savings he suggests ***might*** occur under a loose affiliation.

[1]The Southwest Virginia Health Authority engaged experts with knowledge of national health care trends and who also had familiarity with Southwest Virginia and Northeast Tennessee. Dr. E. Richard Brownlee, the Dale S. Coenen Professor Emeritus of Business Administration at the University of Virginia Darden School of Business, stated that he had entered the assignment as a consultant for the Authority with a perspective that generally favors market dynamics over regulation. But, he added that, four decades-plus experience as a business school professor helped him understand that, as he put it, "there were not many pure markets where competition could occur as described in the textbooks". After meeting with the Parties, reviewing the evidence, and participating in discussions related to the commitments, Dr. Brownlee strongly favored the proposed Cooperative Agreement in Virginia.

Not only do Dr. Kizer's comments ignore the well-developed record, but they also grossly distort the record with respect to cultural integration between the systems. Again, had Dr. Kizer reviewed more of the evidence in the record, he would have known the Applicants engaged expert consultants on the issue of cultural integration. As more fully described below, the systems are very compatible culturally, evidence of which has been provided to the State.

Nowhere is Dr. Kizer's distortion more troubling than in the manner in which he misrepresents the editorial of Dr. Dale Sargent, the Medical Director of Hospitalist Programs for Wellmont.[2] Dr. Kizer cites the editorial to demonstrate cultural incompatibility, selectively quoting only the following very brief excerpt: "Our cultures are incompatible. We could never bury the hatchet." Tellingly, Dr. Kizer omits the remainder of Dr. Sargent's editorial which states:

> The board had one other option, the local option, Mountain States Health Alliance. "Anyone but MSHA!" many said at the start of the process. "MSHA and WHS have been battling one another since the two health systems formed. Our cultures are incompatible. We could never bury the hatchet. What about their debt? Besides, the regulatory hurdles will be too daunting."
>
> Great leaders know how to tune out static and find opportunity. Mountain States proposed, not an acquisition, but the dissolution of both systems with the formation of a new organization that will incorporate the strengths of both. After suspending their skepticism, the Wellmont and Mountain States boards worked through a detailed analysis and came to the conclusion that not only is forming a new organization viable, but it is the obvious choice for the future of health care in our region.[3]

Dr. Sargent then lists the significant benefits to the region from the merger, which Dr. Kizer largely ignores or dismisses:

1. Wellmont and Mountain States spend tens of millions of dollars yearly in duplication of (nonclinical) support services. A combined system will realize huge savings in these areas.
2. The operational savings will be used to support badly needed but unprofitable services such as mental health and drug abuse treatment and access to rural hospitals.
3. A combined system will invest in its existing workforce with improved wages and benefits and expanded training opportunities.
4. A combined system will leverage the clinical and information technology expertise of both to develop care processes that incorporate best practices.
5. A combined system will invest in new high-end services that require significant capital and the recruitment of top talent.

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[2] Dale Sargent, *It's Up To Us: We Alone Can Seize Opportunities For Region's Health Care*, BRISTOL HERALD COURIER, Nov. 8, 2015, *available at* https://swvahealthauthority.files.wordpress.com/2016/09/41-bristol-herald-courier-it_s-up-to-us-we-alone-can-seize-opportunities-for-region_s-health-care.pdf. Staff also engage in the same gross distortion of Dr. Sargent's editorial, which calls into question their credibility as well.

[3] *Id.*

6. A combined system, in partnership with East Tennessee State University and several regional osteopathic medical schools, can support expanded medical education.
7. A combined system will use the energy and innovation formerly spent fostering competition to engage with its communities and measurably improve community health.

Dr. Sargent concisely and accurately summarizes the critical importance of this merger to the community, including the fact that no one else will provide these much-needed benefits to the area:

> **The merger is a once-in-a-generation opportunity for our region to assure that our health care is financially sustainable, clinically excellent, up-to-date and innovative, as well as provides access and needed services for all. If our region doesn't fight for and seize this opportunity, no one else will do it for us.**

Dr. Sargent's perspective is entitled to substantially more weight than the unsupported opinions of Dr. Kizer. Dr. Sargent has practiced medicine in this area for 31 years, and continues to do so now, and has served as Chief of Staff for Bristol Regional Medical Center and Chief Medical Officer of Wellmont Health System. He also attended high school and college in this area. As a practicing physician, he sees firsthand the pressing health care needs of this area, including the recent death of a 31-year-old mother of four due to drug abuse and the lack of inpatient psychiatric care and mental health facilities in the area, a shortage that is especially acute in rural communities.[4] He has conducted and published research on initiatives to achieve efficiencies and improvements in care at hospitals in the GSA.[5] Additionally, Dr. Sargent is serving on the Integration Council and Clinical Council Functional Team using his extensive and firsthand knowledge to try to improve the health care needs of the region, which Dr. Kizer, staff and other critics largely ignore.

While Dr. Kizer references in passing the significant health care challenges facing the region (rural and other underserved communities with "higher than average rates of substance abuse, teen pregnancy, low birth weight babies, chronic illness, illiteracy, and unemployment, among other problems"[6] (Kizer comments at 7)), he does not propose any viable solutions to these problems. Instead, he attacks the comprehensive and detailed solutions the Parties offer.

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[4]Dr. Sargent's curriculum vitae is attached as Exhibit VI.A. *See also* Press Release, Wellmont Newsroom, Dr. Dale Sargent returns to bedside as hospitalist at Lonesome Pine (Feb. 22, 2011) ("One of the region's most respected physicians, who most recently served as Wellmont Health System's chief medical officer, has returned to the bedside as a hospitalist at Lonesome Pine Hospital.").

[5]Dale Sargent et. al, *Reducing health care delivery costs using clinical paths: A case study on improving hospital profitability*, 21:3 J. HEALTH CARE FIN. 18-54 (1995).

[6]These problems have been well-documented in the Parties' submissions, including, in addition to the above, high rates of obesity and a large percentage of children living in poverty. Other issues of concern are the lack of primary physicians in certain areas, as evidenced by the large percentage of hospital patients who do not have a primary care physician when admitted and do not have one to oversee their care when discharged. Other areas which the Parties intend to address are enforceable standards of care developed by a physician led Clinical Council based on best practices for issues such as treatment of sepsis, opioid over-prescribing, blood utilization, and antibiotic overuse. Finally, a Common Clinical IT platform will minimize fragmentation and duplication of care by providing a complete record of the patient's history, including recent MRIs, CT scans, X-rays, and lab results. (Application for COPA, State of Tennessee, at 36-37).

His criticisms are based on only the most general studies or observations about hospital mergers, many of which are dated.[7] Dr. Kizer's opinions are based on generalities without close investigation of the specific facts and conditions of this merger, the communities and their needs, or what the realistic alternatives would provide compared to the accountability and commitments that will be part of the COPA. In particular, Dr. Kizer ignores the financial challenges hospitals face in a region with a large percentage of Medicare, Medicaid, underinsured and uninsured patients.

Dr. Kizer challenges both the likelihood and magnitude of the benefits to be gained by creating a fully integrated delivery system that aligns all services across the New Health System, asserting that it will only provide for "a greater mass of much the same range of services." (Kizer comments at 9) He has not assessed (1) the specific services offered by either Party, (2) the plans to combine, realign, and add new services or (3) any of the specific sources of savings. Indeed, Dr. Kizer provides no evidence supporting his claim that the New Health System will provide "a greater mass of much of the same range of services." He ignores the Parties commitment to provide new addiction treatment services, expanded pediatric specialties, and expanded community based mental health services. He also ignores the fact that integrated health systems are better suited for assumption of risk-based arrangements and the mounting evidence that integrated health systems are better positioned to deliver on the promise of value-based care.

Dr. Kizer also rejects the benefit of the Parties consolidating their trauma units on a single campus, supported by continued emergency and related care in the other facility that currently offers trauma services. As discussed below, the Parties' analysis of potential gains from a consolidated unit is very conservative and consistent with industry standards. Dr. Kizer dismisses these benefits by reference to an academic debate over findings with regard to volumes. (Kizer comments at 19) He fails, however, to address any of the substantial literature that documents efficiency gains from in-market consolidation and realignment of facilities or clinical services.[8]

Dr. Kizer questions the financial viability and benefits of the merger, noting: "Another recently published study that specifically assessed rural hospital mergers found that mergers 'may not improve bottom-line profitability.'"(Kizer comments at 22) However, this same study states that mergers and acquisitions are, **for rural hospitals, "a viable option for maintaining the hospital and the access to care it provides."**[9] His assessment does not specifically assess the financial implications of the proposed merger. He blindly relies on broad studies, selectively provides information from the studies, and ignores the actual facts and evidence that have been provided to the State.

Contrary to Dr. Kizer's assertions (Kizer comments at 8), the Parties have specifically quantified the savings to be achieved and have set out specific details on how they will be achieved. (Application at 82-84) This information is based on detailed analyses undertaken by

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[7]This literature is not relevant given results from more current studies and findings on the modern health care market. LR Burns & MV Pauly, *Integrated Delivery Networks: A Detour On The Road To Integrated Patient Care?*, 21:4 HEALTH AFF. 128-141 (2002).

[8]*See, e.g.*, David Dranove & Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22:6 J. HEALTH ECON. 983-997 (2003).

[9]MJ Noles et. al, *Rural Hospital Mergers and Acquisitions: Which hospitals are being acquired and how are they performing afterward*, 60:6 J. HEALTHCARE MGMT. 395-407 (2015) (emphasis added).

an independent, nationally recognized health care consulting firm which has been provided to the State as evidence. Also, contrary to Dr. Kizer's comments (Kizer comments at 8), the Parties have provided specific details about exactly how funds will be utilized. The Parties have provided details about the need for, among other things, additional outpatient mental health access, residential addiction treatment, expanded access for pediatric services, and investments into expanded research and academic training. (Application at 49-56) In each of these areas, the Parties have articulated the need to engage with the State and with local entities to develop specific objectives to be funded, and the Parties will invest in alignment with the State's objectives.[10]

In reviewing Dr. Kizer's commentary about a common EHR, it is difficult to conclude exactly what his opinion is. In his previous role with the Veterans Administration, he advocated for spending more than $1 billion taxpayer dollars for an EHR, making significant claims about the benefits. Now, he seems to question the benefits, even suggesting a common EHR is costly and may deliver limited benefit. Dr. Kizer then questions the Parties' abilities to implement a common EHR, which he is not qualified to do given that he has no firsthand knowledge of the Parties' expertise in creating or deploying IT systems. Had he merely made a single inquiry, he would have found that Wellmont has been recognized as having among the most successful deployments of the Epic Health Information System.

Dr. Kizer's suggestion that MSHA and Wellmont are seeking to merge "based on the belief that increased size will better position the New Health System to deal with the new health care payment models" (Kizer comments at 7) is false and misleading. The Parties have been very public with the reasoning for the proposed merger. As the Parties have shared with the Department, current inpatient hospital use rates in the region are approximately 126/1,000. There has been overall negative population growth in the service area over the last five years, and the projected growth over the next five years is flat to one percent. The projected inpatient hospital use rates in the region suggest that use rates will decline to between 90/1,000 and 110/1,000. Based on these demographics, the region is expected to see a decline in admissions ranging from 19,000 to 41,000 in the next five to seven years. The combination of the region's declining population and use rates and the poor economy, along with the fact that the region has the second lowest Medicare Wage Index in the United States, create an impetus to rationally consolidate the inpatient capacity in the region.

Dr. Kizer's overly broad statement that the combined health system will be the "overwhelmingly dominant" health care provider in the region relies exclusively on false and speculative statements in staff's papers. This statement fails to reflect that the combined new health system will have significantly smaller market share than its competitors in several outpatient services and (with the exception of a small handful) have less than a majority of the market share for most physician specialties. (Application at 26-27)

Finally and tellingly as discussed below, Dr. Kizer is very critical of programs the Parties have proposed, even though Dr. Kizer has himself proposed and strongly advocated for these

[10]Dr. Kizer states the Parties will have to achieve merger related savings of at least $45 million per year to meet the $450 million spending commitments. (Kizer comments at 8) He is correct, and in fact, the merger related savings are approximately $110 million annually. This has been affirmed by an independent consultant and provided to the State.

same programs. He provides no explanation why this region should be deprived of the benefits of programs that he has specifically endorsed.

B. References To Non-merger Collaborations Are Inapposite.

Dr. Kizer cites to a number of non-merger collaborations in an attempt to argue that a merger is not needed. (Kizer comments at 9) However, the characteristics of those alliances are very different than the proposed merger. For example, none of those alliances appears to involve direct competitors. This is relevant because Dr. Kizer does not state that the FTC or another antitrust agency would permit the Parties to coordinate on contracting for specialists, sharing of competitively sensitive information, allocation of capacity and services or any of the financial and clinical integration that would be necessary for non-merger collaboration. Because the Parties' facilities are in the same geographic region, unlike the alliances Dr. Kizer references, the cited examples are not applicable. Additionally, none of the examples Dr. Kizer cites took place in a region sharing the same challenges as this region such as declining populations, depressed economies, high percentage of Medicare, Medicaid and uninsured and underinsured patients and significant health care challenges. For instance, reimbursement is significantly higher in each of those regions than in applicant's region, as the Area Wage Indexes are higher. Further, none of the collaborations that Dr. Kizer mentions is generating $110 million in annual synergies or committing $450 million to improve health care in economically depressed areas with significant health care challenges.

Dr. Kizer provides only a brief and high-level description of these alliances. He relies heavily on a handful of articles and websites, and his opinions are not based on in-depth research of or personal experience with in-market mergers. Many of his examples and comments are based on a single, non-academic article, "3 Ways Hospitals Can Collaborate Without Merging."[11]

The types of alliances in Dr. Kizer's examples would not allow the Parties to sufficiently address the financial, medical, and community needs of the region. Dr. Kizer asserts a non-merger alliance is a viable alternative to the proposed merger for achieving most if not all of the claimed benefits, including improved population health; realignment of the health care delivery system; coordination and integration of care; and improved efficiency, quality and outcomes. However, even cursory examination of Dr. Kizer's specific examples demonstrates that they are far different from the proposed merger and do not offer these benefits. They largely include arrangements that enable smaller hospitals to achieve greater purchasing power when negotiating with suppliers through approaches like formation of new GPO-related organizations. Moreover, they are often formed by hospitals that are not direct competitors and do not involve the kind of clinical, financial and operational integration contemplated by this merger. In fact, as discussed

[11]Dr. Kizer's discussion of Granite Health, BJC Collaborative, and Trivergent relies mainly on one article. (Kizer comments at 11-3) (*citing* Lola Butcher, *3 Ways Hospitals Can Collaborate Without Merging,* HOSPITALS & HEALTH NETWORKS (July 19, 2016), *available at* http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/. For Advanced Health Collaborative, he relies on a single source. (Kizer comments at 13-4) (*citing* Press Release, Advanced Health Collaborative, Five Maryland-Based Health Systems Come Together to Form "Advanced Health Collaborative," (February 24, 2015) *available at* http://www.ahcmaryland.org/press-release/. For Stratus Healthcare, he relies on one article, from which he directly extracts language without quotes, that is not cited in his paper. (Kizer comments at 14) (*citing* AMERICAN HOSPITAL ASSOCIATION, *Stratus Healthcare Integrated Network: Keeping Health Care Local across Georgia*, *available at* http://www.aha.org/content/15/Stratus%20Case%20Example.pdf.

below, one of the articles cited by Dr. Kizer specifically states that the Parties to an affiliation had to abandon consideration of consolidation of facilities and strategies due to antitrust concerns.

It is very clear that out-of-market acquisitions of the systems would not generate the synergies resulting from elimination of duplicative services within the market. To the contrary, Wellmont and Mountain States would be driven to reduce local jobs and would continue offering duplicative services, with no incentive for either system to reduce unnecessary utilization. Dr. Kizer does not mention that when out-of-market acquisitions occur, the synergies from such acquisitions benefit the acquiring out-of-market entity, and not the local market.[12]

1. The Parties' Relationships With Vanderbilt Are Not Applicable And Provide A Different Set Of Benefits, Unrelated To The Goals Of The Proposed Merger.

A local clinically integrated network between the New Health System and the local physicians, with robust sharing of data, provides a much more meaningful platform than a Vanderbilt affiliation for taking full risk, identifying opportunities in partnership with payers to reduce cost drivers and measuring improvement in the health of the local population. Certainly, the Parties will seek to collaborate with Vanderbilt where possible, but Vanderbilt is located four and one-half hours away, and there would be little synergy that would generate the size and magnitude of what the local merger will generate. Vanderbilt and the Parties do not share the same patient population, other than referrals for quaternary services not provided locally. The referral relationships and possible clinical collaborations with Vanderbilt are very different than the concept of creating $110 million in synergies through the merger to invest in sustaining local hospitals, and no arrangement with Vanderbilt would result in $450 million of investment in the community.[13]

Dr. Kizer's claims also lack merit because he has no firsthand knowledge of the Parties' relationships with Vanderbilt.[14] His commentary, which relies exclusively on press releases and news articles, is unwarranted and uninformed. Mountain States' involvement with Vanderbilt does not provide any synergies locally, and the local physicians are not part of the relationship.

2. References To Other Collaborations Are Similarly Inapplicable.

Dr. Kizer references a number of other collaborations, but does not cite any actual synergies from these alliances—certainly nothing equivalent to the $110 million annually that

[12]Note that Wellmont came to a carefully considered conclusion about the potential for an out of market acquisition as an alternative. Upon reviewing the proposals, Wellmont understood that out of market candidates were surprised by the unique health care challenges of the region and by how efficiently Wellmont was already being managed.

[13]The Vanderbilt Health Network, at the moment, is merely a statewide contracting network, which is something Mountain States has chosen not to participate in as anything more than a messenger model. The Vanderbilt Health Network is also a means by which participating hospitals would acquire health coverage for their employees – again something Mountain States has not found beneficial at this time. While the vision of the Vanderbilt Health Network is to provide information and data, because there is little cross utilization, there is also little utility for those services locally.

[14]Additionally, Dr. Kizer states that Wellmont has achieved cost savings through a purchasing collaboration with Vanderbilt. As Dr. Kizer has not spoken with Wellmont about the Application, he has no basis for this opinion, nor is he qualified to represent the purchasing savings Wellmont may or may not have achieved. His opinion on this is pure speculation.

the proposed merger will generate. The other collaborations that Dr. Kizer cites also did not result in any specific benefits similar to the detailed commitments that the Parties have made, including expanded pediatric access and investment in drug treatment and mental health facilities. These partnerships appear to be limited to joint purchasing, sharing of some data, evaluating utilization improvements (such as analyzing utilization data on MRI for lower back pain), developing tools for asthma, addressing common issues like government relations and some other opportunities that do not raise antitrust concerns.

Dr. Kizer says Granite Health is now "offering more coordinated care with improved patient outcomes at a lower cost," but he provides no evidence of improved outcomes or this lower cost, or the magnitude of cost savings. (Kizer comments at 12) Moreover, Granite Health's collaboration is much less integrated than what the Parties intend to accomplish through this merger: the hospitals are noted to have "distinct" geographic markets and do not consider themselves competitors.[15] The participants themselves acknowledge the inherent risk in an informal partnership, stating: "At its core, the GHN partnership is a handshake relationship among five individuals, so any partner could walk away from the relationship. That's sort of an ongoing risk that we have."[16]

Many aspects of Granite Health's collaborative efforts are distinguishable from the proposed merger, or any health care delivery system merger. The services involved tend to be purchasing rather than care delivery, and the facilities do not have a joint EHR system.[17] The partnership is designed to increase purchasing power, contracting for reference lab services (saving $5 million over 5 years) and combining purchasing on a data analytics software provider.[18] The Granite Health facilities also share an employee benefits provider.[19] While this collaboration may provide for cost-savings, the benefits are categorically different than the critical, population health–focused benefits of the proposed merger.

The BJC Collaborative example is also irrelevant because those hospitals are not located in the same geographic areas and collaborate on issues that do not raise antirust issues such as emergency preparedness, government relations and data analytics. Dr. Kizer says that "instead of taking on risk contracts, the collaborative has worked to develop the foundational skills and

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[15] *Granite Healthcare Network has a goal to drive down costs while increasing quality of care*, N.H. BUS. REV. (June 3, 2011), *available at* http://www.nhbr.com/June-3-2011/Granite-Healthcare-Network-has-a-goal-to-drive-down-costs-while-increasing-quality-of-care/.

[16] Lola Butcher, HEALTHCARE FIN. MGMT. ASSOC., *Making Decisions Across Health System Lines: The Granite Approach,* (March 1, 2013), *available at* http://www.hfma.org/Leadership/Archives/2013/Spring_2013/Making_Decisions_Across_Health_System_Lines__The_Granite_Approach/.

[17] "3 Ways Hospitals Can Collaborate Without Merging," HOSPITALS & HEALTH NETWORKS (July 19, 2016), *available at* http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/.

[18] M. Stempniak, *Five Hospitals Innovate Through Collaboration*, HOSPITALS & HEALTH NETWORKS (May 16, 2012), *available at* http://www.hhnmag.com/articles/5440-five-hospitals-innovate-through-collaboration.

[19] The articles make it clear that the organizational form of GHN is quite different from a fully integrated health care delivery system. For example: "When a GHN initiative requires it, a limited liability corporation (LLC) with its own formal governance is established for that purpose. For example, the medical malpractice insurance company is its own LLC. GHN operations are managed by Rowe and a growing staff that includes data analysts, a medical director responsible for population health management initiatives, and a director of government affairs and communications. Overhead expenses are prorated based on the relative size of the five partners." Lola Butcher, HEALTHCARE FIN. MGMT. ASSOC., *Making Decisions Across Health System Lines: The Granite Approach* (March 1, 2013), *available at* http://www.hfma.org/Leadership/Archives/2013/Spring_2013/Making_Decisions_Across_Health_System_Lines__The_Granite_Approach/.

capabilities needed to manage the total cost of care for a patient population in eight operational areas, including revenue cycle management, emergency preparedness, telehealth, and government relations." (Kizer comments at 12-13) These are skills that do not involve integration, alignment of risk or the ability to take increasing financial risk for the population.

The Parties believe the proposed merger makes moving toward risk-based relationships with payers possible, which is a compelling benefit for the State of Tennessee. Dr. Kizer's statement indicates he believes a non-merger collaboration cannot engage in risk-based arrangements, which supports the Parties' assertion that a merger will more likely and more rapidly achieve needed progress in the realm of risk-based contracting. With a single balance sheet and aligned financials across the entire system, the Parties will be in a better position to take risk.

The Modern Healthcare article that Dr. Kizer cites also reveals key differences between the BJC Collaborative and the proposed merger. The article notes that the systems are "in adjacent regions but are not competitors," and "instead of sharing capital [they] plan to take advantage of their joint purchasing power."[20] The systems are "not planning to form their own GPO, but aim to extract savings by aligning their purchases, such as setting standards for products or coordinating times for buys."[21] Additionally, the BJC Collaborative participants do not plan to form accountable care organizations or negotiate joint contracts with payers. The president of the BJC Collaborative specifically notes: "We're really focused on the expense side of the organization, and to be more specific, we're focused on the non-labor expense side."[22] Any clinical integration this collaborative plans to achieve is very limited.[23]

Dr. Kizer states that the Trivergent collaboration in Maryland had a goal of saving $40 million over three years, but he does not indicate whether the collaboration achieved its goal or whether savings were sought from arrangements for joint purchasing versus integration of health care delivery systems. Dr. Kizer references "significant" savings for Trivergent in the purchase of antibiotics, but he does not provide any detail regarding the savings. However, the article acknowledges that the hospitals' independence does create some inefficiencies: for example, when the hospitals combined for a pharmacy initiative, each hospital needed its own approvals, committee meetings, and formulary changes.[24] Antitrust concerns also limited what initiatives the hospitals were willing to undertake:

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[20]Beth Kutscher, *Bang without the buck?*, MODERN HEALTHCARE (October 27, 2012), *available at* http://www.modernhealthcare.com/article/20121027/magazine/310279960.

[21]*Id.*

[22]*Id.*

[23]*3 Ways Hospitals Can Collaborate Without Merging*, HOSPITALS & HEALTH NETWORKS (July 19, 2016), *available at* http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/.

[24]"For example, Trivergent formed a central pharmacy and therapeutics committee made up of physicians, pharmacists and other clinicians from each hospital. The committee has screened nearly 4,000 drugs to date to start creating a common drug formulary for all three hospitals. 'But each hospital is still independent, so that means each medical staff has to approve any changes to its drug formulary,' Grahe says. 'So the corporate director for pharmacy travels to the three hospitals, goes to their medical executive committees and presents the proposed changes to the formularies.'" *3 Ways Hospitals Can Collaborate Without Merging*, *Hospitals & Health Networks*, (July 19, 2016), *available at* http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/.

> The members of Trivergent Health Alliance created a work team to focus on urgent care facilities and strategy, but it was disbanded. **The antitrust attorney felt that urgent care did not lend itself to the kind of collaboration we were looking at and thought we could run afoul of some of the antitrust laws.**[25]

Dr. Kizer also references a state planning grant Trivergent received to plan for population health management, but he ignores the fact that the Parties will spend at least $85 million to recruit faculty and invest in research, much of which the Parties expect to be seed money for seeking matching grants. (Application at 68-69) The $75 million committed by the Parties for population health can also be used to attract matching grants. Dr. Kizer does not challenge the New Health System's potential for attracting such significant outside investment.

In 2015, Trivergent joined with four independent health systems to form Advanced Health Collaborative to "share ideas and explore opportunities," but Dr. Kizer does not identify a single dollar in synergies or a single resulting improvement in quality from this collaborative.[26] (Kizer comments at 13) The collaborative's clinical initiatives were poorly defined from the outset and not mandated as part of the members' agreement: "AHC initiatives could involve collaborations on population health and care coordination programs, and could include cost savings through shared population health and care coordination resources or services."[27]

The Stratus Healthcare example involves 13 health systems from central and south Georgia, and unlike the Parties to the proposed merger, the members of Stratus Healthcare do not appear to have the same patient population or the same geography. The Stratus Healthcare collaboration started as a "non-equity partnership," suggesting that the alliance did not involve financial commitments or engagement.[28] Expansions into clinical integration and population health efforts have been limited largely to information sharing and collaborating on population data analysis.[29]

Notably, Dr. Kizer does not reference the successful Certificates of Public Advantage where the data demonstrates lower costs and higher value for the combined health systems. Mission Health, operating under a COPA in Asheville, has been held up as one of the best health systems for high value care in the nation and is consistently among the top 15 health systems nationwide, with facilities among the top 100 hospitals in the nation, according to Truven Analytics. Further, according to the State of North Carolina, Mission Health has lower pricing and costs than its peers throughout North Carolina.

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[25] *3 Ways Hospitals Can Collaborate Without Merging*, HOSPITALS & HEALTH NETWORKS (July 19, 2016), (emphasis added), *available at* http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/.

[26] Both this Collaborative and the Trivergent collaborations are in Maryland which operates the nation's only all-payer hospital rate regulation system.

[27] News Release, Advanced Health Collaborative, Five Maryland-Based Health Systems Come Together to Form "Advanced Health Collaborative" (February 24, 2015), *available at* http://www.ahcmaryland.org/press-release/.

[28] AMERICAN HOSPITAL ASSOCIATION, *Stratus Healthcare Integrated Network: Keeping Health Care Local across Georgia*, *available at* http://www.aha.org/content/15/Stratus%20Case%20Example.pdf.

[29] *Id.*

C. The Claimed Benefits Resulting From The Merger Are Substantiated.

In connection with the proposed merger, the Parties have substantiated $110 million of annual savings and committed to an average of almost $50 million per year to benefit the community.[30] By Dr. Kizer's own recognition, the Parties are spending up to $150 million on a common IT platform; spending $140 million on expanded access to needed services, such as a residential addiction treatment facility, outpatient mental health services, and pediatric access expansion; investing $75 million in improving population health; and committing $85 million to health professional training and research and academics. (Kizer comments at 8) The Parties have committed to collaborate with the State to establish priorities they will be measured against. Foundations or other entities that are not fully aligned and incentivized to provide the most high-value health care cannot achieve these financial benefits. The Parties have also committed to increase their charity care beyond what either Party currently provides and take other specific steps to benefit needy patients. (Response to Questions Submitted April 22, 2016)

While the Parties acknowledge Dr. Kizer's service as CEO of the Veteran's Affairs ("VA") health care systems and the difficulties he purports to have faced in consolidating and reallocating services, the Parties respectfully question whether Dr. Kizer's experience is applicable to the proposed merger. The Parties cannot speak to the difficulties Dr. Kizer describes in his responsibility for handling consolidation and reallocation processes, although the Parties do note that Dr. Kizer also states that he successfully merged 52 individual hospitals into 25 medical centers at the VA, which undercuts his claims about the difficulties of consolidation or the lack of need for consolidation. (Kizer comments at 25)

The Parties' leadership is highly trained and experienced and has already made difficult decisions related to consolidation and reallocation.[31] Even a cursory inquiry would have revealed to Dr. Kizer that both Parties have experience of this nature, independently closing service lines and, in one case, a hospital. Dr. Kizer has no firsthand knowledge of steps the Parties have already taken independently, and he is not qualified to challenge this merger based on his incomparable experience at the VA, which is not a local health care system with shared geography and a shared culture.

The proposed Alignment Policy provides that the Parties will conduct a comprehensive review before any consolidation, including consolidation of the two Level I trauma centers. While the Parties have not made any decision with respect to the trauma centers, reconfiguring trauma in the region to more effectively balance needs with resources would make sense. There are only six Level I trauma centers in Tennessee, and two of them, Johnson City Medical Center and Holston Valley, are in the Geographic Service Area 15 miles apart. Of the State's six trauma centers, these two have the lowest volume: even combined, the volumes of the two centers would only rank third in the State. In each of the other four regions where Level I trauma centers exist,

[30] Like the FTC, Dr. Kizer states that he only considered benefits that could be achieved solely by the merger and not by other means. (Kizer comments at 10) As discussed above, this is not the appropriate standard under Tennessee law.

[31] Mountain States Health Alliance closed the Obstetrics Unit at Sycamore Shoals Hospital, and consolidated the services with the new Franklin Woods Community Hospital in Johnson City. Wellmont closed Lee Regional Medical Center. Mountain States closed surgical services at Unicoi County Memorial Hospital and consolidated services with hospitals in Johnson City, TN.

there is also a pediatric trauma center. In this region, there are two Level I trauma centers, a Level II trauma center, and no pediatric trauma center.

There is significant evidence that higher-volume trauma centers lead to better outcomes. (Application at 45, n. 40) Based on long-standing consensus in peer-reviewed literature, the State's well-informed policy is to reduce duplication of trauma services and ensure appropriate geographic distribution to best serve the population. Dr. Kizer questions the correlation between volume and outcomes, referring to studies supporting that concept as "older literature." However, studies as recent as 2013 appear to validate that higher volumes equate to better quality.[32] There is not enough data to challenge this longstanding thesis about trauma, and, until the data proves otherwise, the Parties will continue to agree with the State of Tennessee higher volumes will lead to better outcomes. (Application at 40, n.36)

Dr. Kizer recognizes that the Parties plan to reallocate and expand pediatric and behavioral health services, but he criticizes the Parties for not providing specific plans for operationalizing these goals. Dr. Kizer's comments ignore the fact that antitrust laws prevent the Parties from agreeing to specific plans prior to approval of the Application. The Parties are committed to pediatric specialty centers and emergency rooms in Bristol and Kingsport and to recruitment of pediatric specialties based on need, as well as creating new capacity for residential addiction treatment and expanding mental health access in partnership with local resources. (Application at 5, 56 & 87)

D. The Merger Will Result In Improved Quality.

Dr. Kizer states that the merger is unlikely to improve quality, but he fails to offer evidence to support his conclusory statement. Even after the merger, the parties will face significant competition for inpatient and outpatient services and outmigration to other health systems in Asheville and Knoxville, to smaller community hospitals in Southwest Virginia, and to Roanoke, Virginia and systems where large academic medical centers have substantial resources. (Application at 22) Because patients are mobile and have access to information, and because there are significant high-quality competitors within driving distance, the New Health System will continue to compete based on quality. The Parties have established top-decile performance as the objective so that the New Health System can remain competitive. To this end, the Parties have committed to invest resources and clinical expertise to align care with the goal of reducing variation and improving quality. The Parties have also committed to unprecedented transparency in quality measures, which, along with the investments the Parties have committed to, is an enforceable commitment that the Parties cannot make absent the merger.

Combining transparency with reimbursement incentives tied to quality is proven to improve hospital performance, as supported by several studies. For example, a New England Journal of Medicine study found that financial incentives "are capable of catalyzing quality-improvement efforts among hospitals already engaged in public reporting."[33] The study goes on

[32] JJ Tepas et. al, *High-volume trauma centers have better outcomes treating traumatic brain injury*, 74:1 J. TRAUMA & ACUTE CARE SURGERY 143-7 (Jan. 2013).

[33] Peter Lindenauer et. al, *Public Reporting and Pay for Performance in Hospital Quality Improvement*, 356 N. ENG. J. MED. 486, 494 (2007), *available at* http://www.nejm.org/doi/full/10.1056/NEJMsa064964#t=article.

to note that "participants across the entire spectrum (of hospitals) responded similarly, perhaps equally motivated by the desire to avoid financial penalties."[34] The merger will allow the Parties to collectively align their quality goals with the quality goals that nearly all payers are establishing. The New Health System will have the ability to move the needle on quality of care for the region using data available through a common EHR, strategies deployed by a physician-led Clinical Council directly linked to the New Health System's Quality Committee, and deployment of quality initiatives applicable to the entire combined patient population. Specifically, the New Health System will devote significant resources to eliminating clinical variation (through the use of the EHR's common data and order sets) and promoting regional standardization in physician-developed care plans in partnership with the New Health System's clinically integrated network. Dr. Kizer should have considered these commitments, which the Parties included in the Application and in subsequent filings with the Department.

Dr. Kizer says: "The parties suggest that quality of care will improve because a higher volume of services will be provided." (Kizer comments at 17) This is not accurate and is a misrepresentation of the Parties' public comments. The Parties' argument that higher volume in trauma centers will result in higher quality, while true, should not be conflated to mean the entire system will produce higher quality as a result of higher volumes. Quality, generally, will improve as a result of critical mass in combination with a Common Clinical IT Platform, a physician-led Clinical Council to reduce variation and local governance focused on outcomes and enhanced reporting of quality and performance metrics. All of these mechanisms will be on full display for payers who are incentivizing (or penalizing) the New Health System based on quality measures.[35] (Application at 37-42)

Dr. Kizer himself has advocated for the same quality-of-care principles that the Parties intend to implement with the merger-generated savings:

> In conclusion, the reengineering of the Veterans Health Administration appears to have resulted in dramatic improvements in the quality of care provided to veterans. Many of the principles adopted by the VA in its quality-improvement projects, including an emphasis on the use of information technology, performance measurement and reporting, realigned payment policies, and integration of services to achieve high-quality, effective, and timely care, have recently been recommended for the health care system as a whole by the Institute of Medicine. Our findings suggest that initiatives based on these principles may substantially improve the quality of care.[36]

As noted above, Dr. Kizer acknowledges that re-engineering the VA system, which resulted in dramatically improving quality of care, reducing per capita expenditures by more than

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[34] *Id.* at 494.

[35] It has been difficult for either system, alone, to enter into full risk based arrangements that blend quality with price. Mountain States attempted this with its own insurance plan, but Wellmont, as a competitor, never participated as a provider in the plan. As a result, Mountain States closed the insurance plan. The intent of the insurance plan was to gain enough critical mass to use incentive based payment to drive quality. The plan simply did not work because it could not generate the number of lives necessary.

[36] Ashisha Jha et. al, *Effect of the Transformation of the Veteran Affairs HealthCare System on the Quality of Care*, 348 N. ENG. J. MED. 2218-27 (2003).

25 percent and reducing operating costs by almost a billion dollars per year, included ***merging*** some 52 individual hospitals into 25 two- or three-campus medical centers. (Kizer comments at 25) Thus, Dr. Kizer's own experience substantiates that mergers can generate significant savings and dramatically improve quality of care.

Importantly, Dr. Kizer does not dispute that the Parties' commitments to the Common Clinical IT Platform and increased transparency on quality measures will improve quality. In fact, Dr. Kizer has advocated that the VA should implement measures like this to restore trust in VA health care. Specifically, Dr. Kizer has stated that focusing and reporting on certain important quality metrics is a "good start that will improve with use and would help to hold the VA accountable for results."[37] Dr. Kizer advocates for "performance-reporting initiatives" and "making performance data broadly available" because "[t]ransparency may expose vulnerabilities, but it is easier to improve when weaknesses are publicly acknowledged."[38] Likewise, Dr. Kizer stresses the importance of a "new access strategy that draws on modern information and advanced communications technologies to facilitate caregiver-patient connectivity and that uses personalized care plans to address patients' individual access needs and preferences."[39] These are exactly the quality improvement measures the New Health System plans to undertake.

One of the major projects of Dr. Kizer's organization, the Institute for Population Health Improvement, is collecting and disseminating patient safety and quality improvement data from California hospitals "with the endpoint of improving patient safety and quality outcome measures for California hospitals and patients."[40] The project is part of a Medi-Cal Quality Improvement Program that is employing population health initiatives throughout the state to improve California's Medicaid program.[41] The program's annual report emphasizes focus on the health needs of the population, not just the underlying socioeconomic determinants of health. For example, the program works to implement tobacco cessation[42] and acknowledges that creating an obesity program is important for health promotion and disease prevention.[43] The report stresses the importance of health care systems in improving population health:

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[37]Kenneth Kizer & Ashisha Jha, *Restoring Trust in VA Health Care*, 371 N. ENG. J. MED. 295, 297 (2014), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1406852#t=article.

[38]*Id.* at 297.

[39]Kenneth Kizer and Ashisha Jha, *Restoring Trust in VA Health Care*, 371 N. ENG. J. MED. 295-97 (July 24, 2014).

[40]Moreover, one of the major projects of Dr. Kizer's organization, the Institute for Population Health Improvement, is to collect and disseminate patient safety and quality improvement data from California hospitals "with the endpoint of improving patient safety and quality outcome measures for California hospitals and patients." INST. FOR POPULATION HEALTH IMPROVEMENT, UC DAVIS HEALTH SYSTEM, *IPHI partners with the Hospital Quality Institute to support quality improvement and patient safety activities*, *available at* http://www.ucdmc.ucdavis.edu/iphi/Programs/HQI/index.html.

[41]UC DAVIS HEALTH SYSTEM, MEDI-CAL QUALITY IMPROVEMENT PROGRAM, Oct. 1, 2013 - Sept. 30, 2014, https://www.ucdmc.ucdavis.edu/iphi/Programs/MediCal/index.html.

[42]Desiree Backman, & Kenneth KizerINST. FOR POPULATION HEALTH IMPROVEMENT, UC DAVIS HEALTH SYSTEM, *Medi-Cal Quality Improvement Program: Third Annual Report to the California Department of Health Care Services*, at 32 (December 2014), *available at* https://www.ucdmc.ucdavis.edu/iphi/Programs/MediCal/resources/2014-Annual-Report_Medi-Cal-QuIP.pdf,.

[43]"As part of DHCS' commitment to deliver high-quality care, an assessment was conducted in 2012 to inventory all Departmental quality improvement (QI) efforts in the areas of clinical care, health promotion and disease prevention, and administration. Although a wide variety of QI activities was reported in the areas of clinical care and administration, little activity

> There is a need to create a stronger bridge between health care and public health to transform our disease management, sick care system, into a true health care system that addresses population health. This is especially critical given that merely four modifiable health behaviors—lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption—are responsible for much of the illness, suffering, and early death related to chronic disease. [44]

The Parties plan the same focus on population health in this region that Dr. Kizer is undertaking in California.

In his role at the VA, Dr. Kizer made integrated care delivery and the creation of clinical networks a priority in the system's overhaul. For example, changes included the creation of twenty-two Veterans Integrated Service Networks ("VISNs"), each with an integrated delivery system[45] combining several hospitals and other medical facilities.[46] These VISNs, which Dr. Kizer promotes in his writings as a way to "reduce care fragmentation,"[47] exemplify the type of clinical, administrative and technological integration proposed in the potential merger. The Parties have proposed to do exactly what Dr. Kizer has strongly advocated for. Unfortunately, in his eagerness to support staff's opposition to the merger, Dr. Kizer ignores the specific policies he has endorsed that would benefit the residents of the region. He provides no adequate explanation as to why the region should be deprived of the benefits of better health care that are achievable through this merger.

The proposed transaction represents far more than a traditional merger of two independent organizations into a single, commonly controlled and operated health system. The Parties intend to affirmatively transform two traditional delivery systems into a single, fully integrated health care delivery system ("IDS") of hospitals, outpatient facilities, physicians and other providers in the New Health System, working collaboratively with the region's independent physicians. The New Health System IDS will be aligned to meet the needs of the

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was noted in the area of health promotion and disease prevention. Most notably, there was an absence of QI activities in the areas of healthful eating, physical activity, and obesity prevention despite the high rates of overweight and obesity among children (29.6 percent), adolescents (35.2 percent), and adults (65.7 percent) enrolled in the Department's largest program, Medi-Cal. The results of the assessment provided a call to action to develop, implement, evaluate, and sustain a comprehensive obesity prevention program that links the many facets of the health care delivery system to NEOP's existing community-based efforts. At this time, unfortunately, there are no programmatic funds available for such a program." *Id.* at 215 (internal citations omitted).

[44] *Id.* at 33.

[45] Kenneth Kizer & R. Adams Dudley, *Extreme makeover: Transformation of the Veterans Health Care System*, 30 ANN. REV. PUBLIC HEALTH 313-39 (Apr. 2009) ("The selection of 22 VISNs was based on a judgment about the best distribution of care delivery assets matched with geographic catchment areas that had~250,000 veteran users. The catchment areas of the VISNs were determined primarily according to prevailing patient referral patterns, the ability of each VISN to provide a continuum of primary to tertiary care with VA assets, and state or county jurisdictional boundaries. A typical VISN encompassed 7–10 VA hospitals, 25–30 ambulatory care clinics, 5–7 nursing homes, 1–2 domiciliaries, and 10–15 counseling centers.").

[46] As described by Dr. Kizer, "the VISN has become the Veterans health care system's basic budgetary and management unit. It provides a structural imperative for pooling and aligning resources to meet local needs, coordinating services, reducing service duplication and administrative redundancies, improving the consistency and predictability of receiving high-quality care, and, overall, optimizing health care value. The VISN is designed to promote both vertical and 'virtual' integration." Kenneth Kizer et. al, *Reinventing VA health care: systematizing quality improvement and quality innovation*, 38:6 (Supp. 1) MEDICAL CARE 1-11(2000).

[47] Kenneth Kizer & R. Adams Dudley, *Extreme makeover: Transformation of the Veterans Health Care System*, 30 ANN. REV. PUBLIC HEALTH 313-39 (Apr. 2009).

full population of the Geographic Service Area in the most effective and appropriate location of care, with the requisite investments and financial commitments by the New Health System. Achieving IDS goals of enhanced value involves coordination across the health care delivery system on best location of care, care closer to home and approaches that rely on enhanced IT investments and platforms and their integration, strong physician leadership and clinical alignment around health, outcomes, access and quality. The New Health System will be accountable, both clinically and fiscally, for the clinical outcomes and health status of the population it serves, and its commitments and plans involve systems both to manage and improve these initiatives. The New Health System's IDS will be fully aligned, complementary to and supportive of community health initiatives that will be funded in large part by the New Health System.

The New Health System IDS will replace the largely fragmented health care delivery system in the Geographic Service Area. The IDS will operate based on proven approaches to care systems and embedded protocols, through clinically aligned networks and a common EHR system that enable independent physicians and other providers to actively participate in and benefit from the New Health System's investments and infrastructure. The New Health System will improve the efficiency and effectiveness of care and operations by combining facilities and resources. The Parties' efforts to combine will focus on clinical consolidation, realignment and re-purposing resources that maintain or enhance services at reduced costs with improved quality. The new IDS provides the platform through which the New Health System will work with payers to align incentives and initiatives. Independent physicians and providers will also have access to the system and its benefits. Newly developed leadership, clinical council, investments, infrastructure and quality initiatives will further facilitate enhanced partnerships with payers on risk-based and value-based initiatives to serve common interests of improved outcomes and savings.

The New Health System's specific plans for its IDS share the attributes of successful IDSs, including some operating in largely rural communities with similar significant health challenges and diverse populations. One such IDS is Geisinger Health System.[48] Extensive studies of IDSs, including studies commissioned by the Commonwealth Fund, indicate there is no one-size-fits-all model for "ideal" integrated health delivery.[49] Yet, based on these and other studies, successful IDSs share several key characteristics:

[48]Geisinger Health System is often referenced as an example of a successful IDN operating in a largely rural environment. See, for example, Douglas McCarthy and Kimberly Mueller; Organizing the U.S. Health Care Delivery System for High Performance; July 2009, which includes a comprehensive review of Geisinger Health System's IDN. Geisinger shares some of the same geography and health challenges as Ballad Health, It is described as: "A nonprofit, physician-led integrated health system serving an area with 2.6 million people in 43 counties of rural northeastern and central Pennsylvania through three acute/tertiary/quaternary hospitals and an alcohol/chemical dependency treatment center; a multispecialty group practice employing more than 740 physicians; 50 practice sites including 40 community practice clinics; the 220,000-member Geisinger Health Plan, which offers group, individual, and Medicare coverage and contracts with more than 18,000 independent providers including 90 hospitals; the Geisinger Center for Health Research; and medical education programs. Annual patient volume exceeds 40,000 inpatient discharges and 1.5 million outpatient visits." For further discussion on the Geisinger Health System IDN and its programs and environment, also D. McCarthy, K. Mueller, and J. Wrenn, Geisinger Health System: Achieving the Potential of System Integration Through Innovation, Leadership, Measurement, and Incentives, The Commonwealth Fund, June 2009.

[49]The Commonwealth Fund commissioned studies of 15 integrated systems, results show diversity of organizational arrangements accomplishing re-alignment of health care, and the importance of health system led initiatives. Several involve very

- They provide patient-centered care and involve significant financial and clinical accountability by the lead organization.
- They frequently involve common ownership and control of hospitals and other facilities.
- They involve clinical integration and re-alignment.
- They are supported by EHR, other IT platforms and shared data and systems that support the IDS, independent physicians and patients.
- They have clinical support, particularly in terms of strong physician leadership and communication.
- They use evidenced-based population health medicine.
- They involve initiatives to motivate and change patient behavior.

A particularly important feature is the fiscal and clinical accountability of the IDS to the population it serves and the clinical resources it manages. Ownership, rather than contract between otherwise independent entities, may be the most effective way to achieve this accountability.[50] The New Health System's IDS shares these attributes. Moreover, the New Health System's specific plans and the commitments made to the State reinforce each of these important IDS attributes and hold the Parties accountable to the State, the community and especially to the residents of the area.

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close integration and control by health systems, some with health plans and others without. The Commonwealth Fund study divided IDNs into 4 models, the first of which involved fully integrated health systems with health plans (e.g., Kaiser), and the second involved fully integrated health systems without plans. *See* Anthony Shih et. al, COMM'N ON A HIGH PERFORMANCE HEALTH SYSTEM, THE COMMONWEALTH FUND, *Organizing the U.S. Health Care Delivery System for High Performance*, 4-8 (August 2008) ("THE COMMONWEALTH FUND").

[50]Specifically, the Commonwealth Fund Commission on a High Performance Health System identified six attributes: (1) Clinically relevant patient data are available to all providers at the point of care through electronic health record systems (2) Patient care is coordinated among multiple provider and transition of care is actively managed, (3) Providers have accountability to each other, review each other's work, and collaborate to reliably deliver high quality, high value care, (4) Patient access to appropriate care and information is easy, with multiple points of entry to the system, (5) Clear accountability exists for the total care of the patient, and (6) the System is continuously innovating and learning to improve quality, value and patients' experience. THE COMMONWEALTH FUND at 9-15. Ballad Health's planned IDN includes each of these 6 attributes, which are also strongly reinforced by commitments to the State or to the community. Other authors have studied IDNs with similar findings. Alain Enthoven's attributes of a successful IDN include: shared value and goals with physician leadership and accountability, patient-centered and population health focus that provides multiple points of access to care, inclusion of patients in health care decision-making, and resources directed at improving health care in the population or community served, coordination of care and sharing of information across providers, financial incentives aligned with delivering high quality, affordable care among providers, deploying evidence-based best practices to minimize quality shortfalls and variations in care, accessible and shared electronic medical records among providers to enable tracking each patient through the provision of care, performance review, and status of health problems across provider panels, ability to "right-size" capacity, and continuous innovation and learning to improve value. Alain C. Enthoven, , *Integrated Delivery Systems: The Cure for Fragmentation*, AM. J. MANAGED CARE 284, 285 (2009). The National Public Health and Hospital Institute (NPHHI) recognizes these same attributes of success. *See* NPHHI, Literature Review, Integrated Health Care." *See also* WA. ST. HOSP. ASS'N, GOVERNING BD. MAN., Chapter 11 at 3 (2006); Federico Lega, *Organizational Design for Health Integrated Delivery Systems: Theory and Practice*, SCIENCE DIRECT, HEALTH POLICY, 258-79 (2007) ("provides or aims to provide a coordinated continuum of services to a defined population and are willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served."); Keith D. Moore& Dean C. Coddington, *Multiple Paths to Integrated Health Care*, HEALTHCARE FIN. MGMT., (December 2009) ("…uses corporate structure, strategic alliances, governance, management approaches, culture, financial practices, clinical information systems, and other tools to facilitate and insure delivery of this type of care.").

E. The Merger Will Improve Population Health.

Dr. Kizer ignores the fact that without the synergies from the merger, the systems would not have the financial wherewithal to spend incrementally on community and population health beyond current efforts. Nor does he consider that realignment of care into an integrated delivery system supported by a common IT platform and a physician-led Clinical Council is a key element in achieving critical population health goals. Keeping sustainable and financially sound care delivery systems in place is critical to population health, as is the ability to partner with payers across a larger population to meaningfully share in risk.

As revenue pressure increases and costs continue to rise, the resources that Wellmont and Mountain States can devote to population health programs and community health improvement will diminish. For example, prior to the announcement of the proposed merger, both systems had already independently begun efforts to reduce the number of residency slots they were funding. As projected volumes decline, the more than $19 million in rural hospital operating losses that the health systems are already absorbing are likely to worsen. The systems will have to make choices—like the decision to eliminate residencies—about what services to eliminate or close. Absent savings from the merger and a commitment to fund these initiatives as outlined in the Application, there is no certainty about future funding.

To develop the proposed population health programs, which are one of the merger's most important features, the Parties carefully examined state and nationally reported health data for the region, reviewed the Tennessee State Health Plan, the Virginia Department of Health Plan for Well-Being, the Southwest Virginia Health Authority Blueprint. The Parties also contracted with ETSU School of Public Health to conduct multiple community-based listening sessions on local health priorities using the World Café model and organized subject matter experts into four Community Work Groups to identify key health priorities and promising solutions for health in the region. These four Work Groups held numerous town hall meetings throughout the region focused on four issues: Mental Health and Addiction; Healthy Children and Families; Population Health and Healthy Communities; and Research and Academics. Representatives of the Parties attended the meetings, which also included business and community leaders from throughout the region and master's and doctoral level students from ETSU. (Application at 50-51) The Application includes the charters and membership lists of each Work Group and their extensive schedule of public meetings. (Application Exs. 8.2A, 8.2B, 8.3) The Parties jointly funded this effort, which was specifically in connection with proposed merger and would not have been undertaken otherwise.

Dr. Kizer did not review the Tennessee and Southwest Virginia responses delivered post-Applications, which provide significant additional detail on the areas of focus, potential solutions and measurement of population health improvement, clinical integration and other initiatives. He also fails to recognize the role of the Index Advisory Group, which will provide comment and suggestions on key areas of population health investment and measurement. The Advisory Group recently presented the Parties with a draft of the Index, which was substantially similar to the material initially provided to the Department.

The areas of focus for the region will be determined in consultation with the State before the COPA is approved, so the initial work between the New Health System and ETSU on the

Community Health Improvement Plan ("CHIP") will be to match local needs, capacity and interest with promising strategies in order to create detailed implementation plans using merger-generated savings. The New Health System and ETSU will collaborate closely with the State throughout the process. The achievement of each commitment will be subject to active supervision and will be reviewed regularly. Changes to the CHIP will be made with the State's input as needs change, or programs fail or succeed. The CHIP and its anticipated programs (to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and neonatal abstinence syndrome) are described in detail in the Parties' post-Application submissions. (Addendum No. 1 to the Application, submitted March 16, 2016 at 7-8; July 13, 2016 Submission at 13 and Exs. 21 & 22)

The New Health System and ETSU will develop the CHIP in the context of a larger Accountable Care Community effort, which will involve decision makers from government (public health, schools, law enforcement, housing), business, faith-communities and others working on the broad regional issues of economic development, education and health. (Application at 50-51) The New Health System has committed to funding and helping to lead this effort, and executives of the New Health System have prior successful involvement and leadership experience with similar collaborative efforts elsewhere.

Contrary to Dr. Kizer's assertion, this commitment goes well beyond the minimal requirements of the typical Community Health Needs Assessment ("CHNA"), including the IRS's newly issued requirements. First, the scale is substantially different. Should the COPA be granted, the Parties have committed to 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. Second, the IRS continues to require hospital-by-hospital CHNAs. In rural areas, where a small local hospital losing money has little ability to influence community health, regional resources and planning are required. Third, the IRS admittedly has few resources to monitor compliance with the production of a high-quality CHNA, much less monitor the actual implementation. Partly for this reason, 23 states have more stringent requirements that non-profit hospitals demonstrate a community benefit. Virginia is among the states requiring such a demonstration, specifically as a condition for a certificate of public need approval.[51] The proposed CHIP goes far beyond CHNA standards and demonstrates the Parties' willingness to work with Tennessee and Virginia to exceed federal standards.

The community members participating in the Community Work Group town hall meetings recognized the role of social determinants in regional health, even without the prior benefit of Dr. Kizer's perspective. Issues such as lack of education, employment and transportation are all crucial for health improvement and were cited frequently by community members.[52] In spite of his definition of population health, Dr. Kizer takes a very narrow view of population health in a number of instances. For example, he cites only the $75 million investment as a "population health" investment. He seems unaware of the access challenges that rural Appalachia faces and that expanded access to mental health, addiction and pediatric

[51]For a summary of community benefits laws by state, see THE HILLTOP INST., COMMUNITY BENEFIT STATE LAW PROFILES (through May 2016), *available at* http://www.hilltopinstitute.org/hcbp_cbl.cfm.

[52]Summaries of the town hall meetings are available here, http://becomingbettertogether.org/get-involved/apply-to-join-a-workgroup/.

services is critical in the region to improve the overall health of the population. Individuals with behavioral issues are far less likely to be screened and treated for chronic conditions such as diabetes and hypertension, and conversely, individuals with chronic diseases are much more likely to suffer from depression. The Parties propose to invest an additional $140 million in providing these and other critical services over the next decade. Expanding these services in the community and better integrating behavioral health in primary care are key to improving overall health.

Dr. Kizer also fails to recognize the potential for long-term population health improvements through investment in maternal health and pediatric services, which can drive improved social determinants such as education and income. Numerous studies indicate that investment in maternal and child health services has a significant future return on improved health, which in turn leads to improved education and employment attainment. In furtherance of its commitment to population health, the New Health System has committed to improving community health through investment of not less than $75 million over ten years in science and evidence-based population health improvement. The funding may be committed to the following initiatives, as well as others as determined based upon the 10-year action plan for the region:

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.
- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.
- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the 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.
- ***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.

Dr. Kizer also fails to recognize the role that the $85 million in increased funding for research and academics will play in improving population health. For example, this region of Appalachia is heavily impacted by the epidemic of addiction. Recruitment of research faculty funded by the investment will net returns for the region by helping the area's academic institutions compete for National Institutes of Health grants and other sources of funding for

research in this underinvested area. With the passage of the 21st Century Cures Act, $1 billion of new investment is available in this area of research alone. The timing could not be better for the New Health System and its academic partners. To compete for these funds and others, the New Health System needs to invest in the faculty, but that investment will not be available without the synergies resulting from the merger.

With respect to recruitment and retention of physicians in this rural region, the location and design of medical school and residency programs are critical to the choice of specialty and post-residency practice sites for physicians.[53] It is also likely that health systems will increasingly be asked to contribute more to training their own physicians.[54] The New Health System must maintain and expand residency positions and support the local education of medical students, nurses and allied health providers to maintain local access to care for individuals often challenged by lack of transportation, child care and job flexibility. As stated previously, both health systems were in the process of eliminating dozens of residency slots prior to filing the Application. The State has a compelling interest in preventing the ongoing reductions in these slots.

The Parties agree with Dr. Kizer that the New Health System "cannot by itself fix the social and environmental problems that negatively impact health" (Kizer comments at 21), and have maintained in the Application and in meetings with the Department that they should not be held solely responsible for moving the needle on complex multifactorial health problems such as obesity. The New Health System has agreed to invest hundreds of millions of dollars and use its considerable management expertise and position in the community to ensure that the short-term and intermediate goals for each program are achieved through contracting or direct provision of services and that efforts are implemented efficiently and according to best practice.

The region has endured struggling and failed attempts in this vein, such as HEAL Appalachia which has suffered due to a lack of funding. However, the region has demonstrated it can work together across the continuum of care and across industry sectors, and leadership exists with significant experience inside and outside the health systems.[55] Sustainable investment for collaborative infrastructure is the missing piece in the region. The Parties have committed to this investment, and to the corresponding programming, but these commitments are not possible without the synergies the merger will bring and continued local governance of the health systems. Dr. Kizer makes much of his own self-described background but fails to acknowledge the significant experience and expertise of the leadership of Mountain States and Wellmont.

Finally, Dr. Kizer fails to acknowledge what is potentially the largest direct social-determinant benefit of the proposed merger: the retention of employment and income in the

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[53] ROBERT PHILLIPS ET. AL, ROBERT GRAHAM CENTER, SPECIALTY AND GEOGRAPHIC DISTRIBUTION OF PHYSICIAN WORKFORCE: WHAT INFLUENCES MEDICAL STUDENT & RESIDENT CHOICES (2009).

[54] *See, e.g.*, INST. OF MED., GRADUATE MEDICAL EDUCATION THAT MEETS THE NATION'S HEALTH NEEDS: RECOMMENDATIONS, GOALS, AND NEXT STEPS (July 2014), *available at* https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2014/GME/GME-REC.pdf.

[55] *See* Overview Response Exhibit A to the November 22, 2016 Request for Information which provides a representative list of all the experience Mountain States and Wellmont executives have with multi-stakeholder collaborative efforts.

region. The Parties have indicated that an expected 1,000 jobs would be eliminated if both systems were absorbed by larger, out-of-market systems – many more than with the proposed merger of the Parties. Most back-office and corporate functions would be eliminated locally to capitalize on synergy for the acquiring system – a system that would be absorbing almost $1 billion of debt in the case of Mountain States or almost $500 million of debt in the case of Wellmont. Dr. Kizer's contention that the need for these jobs will continue to exist with two competing system in the market, even following an out-of-market acquisition, is incorrect: evidence shows that out-of-market acquisitions of health systems result in closure of corporate offices and functions locally.[56]

While the proposed merger will result in synergies between the two systems as duplicative administrative functions are consolidated, the essential fact remains: the functions will remain in the community, minimizing the negative job impact. The New Health System will redirect resources resulting from these synergies to fund the commitments that themselves will create new jobs. Right-sizing corporate functions by eliminating wasteful duplication and redirecting these scarce resources to create high-wage jobs related to needed clinical and population health improvement is a compelling benefit of this proposed merger.

F. The Alleged Potential Impediments To Implementing The Merger Are Without Foundation.

In alleging several potential impediments to implementing the merger, Dr. Kizer ignores the extensive work the Parties have done in preparation. Further, his references to allegedly unsuccessful mergers (of which he does not purport to have firsthand knowledge) do not address the level of the planning that was undertaken. Dr. Kizer has no firsthand knowledge of the work that has been done relative to the proposed merger and is therefore unqualified to render an opinion.

1. The Parties Have Undertaken Substantial Merger Implementation Planning.

The Parties have created seventeen Functional Teams that have been working diligently on merger planning for more than six months, with oversight from antitrust counsel. These teams include: Clinical Council, External Affairs, Finance, Human Resources, Information Technology, Strategy, Post-acute Operations, Quality, Research and Academics, Managed Care, and Supply Chain. Each team has developed a plan for pre-merger priorities, "first 30 day" priorities and long-term priorities. The work these teams are performing is being reported to an Integration Council composed of senior executives from each system.[57] The Integration Council then reports to the Joint Board Task Force, which is composed of board members and the CEOs of each system. [58] The Joint Board Task Force will be the governing body of the New Health System upon closing.

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[56]*See* Laura Layden**,** *HMA informs state of possibly up to 400 layoffs*, NAPLES DAILY NEWS, Jan. 28, 2014, *available at* http://archive.naplesnews.com/business/hma-informs-state-of-possibly-up-to-400-layoffs-ep-313072986-330749621.html.

[57]Application at Exhibit 10.2 (Press Release, Wellmont Health System & Mountain States Health Alliance, Wellmont Health System Mountain States Health Alliance Name Members of Integration Council, Apr. 2, 2015).

[58]Application at Exhibit10.2 (Press Release, Wellmont Health System & Mountain States Health Alliance, Wellmont Health System Mountain State Health Alliance Name Members of Joint Board Task Force, May 4, 2015).

The Parties have undertaken significant planning internally and are following a robust governance and project management structure to ensure accountability. The Joint Board Task Force has also adopted best practice governance policies, which were validated by outside experts in not-for-profit health system governance. The Joint Board Task Force has received training, and each system's board has separately engaged in training to prepare for the future. The Joint Board Task Force has appointed a Governance Committee, which has populated the committees of the New Health System board based on competencies and the experience of each committee member. (Application at Ex. 10.1)

2. Dr. Kizer Fails To Identify Any Significant Cultural Differences.

Dr. Kizer contends that cultural differences could impede the merger, but he fails to identify what those cultural differences are and merely states that it is "logical and reasonable to expect that there will be some degree of difficulty . . . ." (Kizer comments at 24) He does not identify the "degree of difficulty," and his basis for concern about cultural differences appears to be drawn from his gross distortion of Dr. Sargent's editorial, discussed above.

In fact, the Parties engaged leading consultants to conduct a governance audit and a culture audit of each organization. The culture audit revealed that there is very little difference between the cultures of the systems. Further, the Joint Board Task Force has been functional for more than one year, and the culture of the Joint Board Task Force has been exceptionally positive and strongly focused on achieving the results and promise of the merger. Dr. Kizer also ignores the extensive discussion in the Application describing the specific steps the Parties will take to align culture, including the composition of the New Health System's board, the equal representation of the systems on board committees, the physician composition of the new Clinical Council and the adoption of a Common Clinical IT Platform. (Application at 78)

Without providing evidence specific to the Parties, Dr. Kizer asserts that the merger will fail due to the inability of the system cultures to integrate: "It is well established in health care, as well as in other enterprises, that difficulty in integrating and unifying disparate organizational cultures is a primary reason why mergers do not achieve their anticipated benefits and often fail." (Kizer comments at 22-23) However, the source that Dr. Kizer cites to support his argument offers a much more nuanced approach to merging cultures, providing specific recommendations to assure culture integration and noting success stories in which culture integration has been an important component of successful mergers.[59] Further, Dr. Kizer makes no mention of the culture assessments that independent, nationally recognized firms performed on the Applicants, which concluded that the cultures between the Applicants were compatible.

Dr. Kizer cites his experience as the CEO of the VA system to illustrate the difficulty in changing a culture. However, according to Dr. Kizer, the problems he encountered there were fundamental problems such as lack of accountability and the need to dramatically improve poor patient care (Kizer comments at 25). Dr. Kizer does not allege those problems exist for the Parties, and the comparison is inapplicable.[60]

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[59] LARRY SCANLAN, HOSPITAL MERGERS - WHY THEY WORK, WHY THEY DON'T (2010).

[60] Unfortunately, Dr. Kizer apparently failed to fix those fundamental problems. Within the last month, a series on WJHL, a local CBS affiliate, highlighted abuse of veterans and the lack of accountability in the system. *See, e.g.* Nate Morabito, *American*

3. The Parties Have Adequate Plans For Closing Or Realigning Facilities And Services.

Dr. Kizer does not take issue with the need to realign duplicative services or the cost savings that will result from such realignment. Instead, he states it is unclear how the New Health System would address the challenges in closing or consolidating facilities and services. Again, Dr. Kizer ignores the comprehensive Alignment Policy adopted by the New Health System and described in the Application, which provides for a rigorous, systematic method for evaluating the potential merits and adverse effects related to access, quality and service and requires an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. (Application at 76-77 and Ex. 11.13) For two years after formation of the New Health System, a super majority vote of the Board will be required to consolidate a service in a way that results in discontinuation of that service in a community. (*Id.*)

4. Dr. Kizer's Alleged Problems With Consolidation Of EHR Systems Are Baseless.

Dr. Kizer falsely asserts that the Parties do not articulate why moving to a Common Clinical IT Platform is necessary. In fact, the Parties provided detailed answers to questions that the Department posed about this issue. (Response to Questions Submitted April 22, 2016, Ex. 2-Description of the Parties' Plan for Electronic Health Records Systems & Ex. 4-Timeline for Implementation of the Common Clinical IT Platform) The interoperability the Parties will achieve is consistent with current national policy, based on the widely accepted principal that decreasing clinical variation, commonality of data and ease of use by providers is critical to the improvement of quality and reduction in overall cost.

Dr. Kizer mentions that Mountain States and Wellmont each have their own EHRs and questions why the Parties cannot simply continue using their existing systems. Cerner has acquired Mountain States' Soarian system, and the system will be phased out. Mountain States will eventually need to acquire a new system, or evolve to Cerner. If Mountain States evolves to Cerner, each hospital system will have hardwired different systems for the next generation, permanently making it more complex for splitter physicians and making elimination of variation very difficult. Even if Mountain States were to acquire EPIC, which Wellmont currently uses, different EPIC systems do not necessarily communicate. If the Parties want a seamless IT system that benefits physicians and patients and lends itself to opportunities for research and standardization of care, Wellmont and Mountain States should be on the same platform. Dr. Kizer himself identifies the many benefits of a system-wide EHR based on his experience at the VA. (Kizer comments at 25)

Legion rep "horrified" by VA discipline, WSJL, Nov. 30, 2016. National stories about the VA system have exposed disgraceful treatment of its patients, up to and including reporting on deaths of patients who could not access care. *See, e.g.*, Curt Devine, *307,000 veterans may have died awaiting Veterans Affairs health care, report says*, CNN, Sept. 30, 2015.In this region, the Parties have had difficulty in getting veterans access in local hospitals due to VA policies *See* Josh Smith**,** *Two years after reforms, some Tri-Cities veterans still having to wait for medical care*, WJHL (Jul. 7, 2016), *available at* http://wjhl.com/2016/07/07/two-years-after-reforms-some-tri-cities-veterans-still-having-to-wait-for-medical-care/ . The culture of VA cannot be compared to the culture at Wellmont and Mountain States, and is not relevant to the Application.

Dr. Kizer expresses doubt about whether the Parties could successfully deploy such a system. However, he notes that Wellmont launched its EPIC system in 2014 (Kizer comments at 26) and he does not assert that Wellmont experienced any problems in that conversion. Given that Wellmont recently executed a successful deployment, the Parties have the expertise and resources locally to handle the rollout of a system-wide Common Clinical IT Platform. [61]

After questioning why the Parties need a Common Clinical IT Platform, Dr. Kizer says that "there could be potential benefits to having a single EHR in the new health system." (Kizer comments at 27) He then qualifies this statement by saying the potential benefits must be viewed with an eye toward the substantial financial and operational impacts of changing EHR systems. However, Wellmont has successfully completed a conversion, and now has the requisite experience to work with Mountain State's legacy system should the EPIC platform be selected.

Dr. Kizer's commentary on EHR is contradictory. He vacillates between saying there could be potential benefits and suggesting significant pitfalls (Kizer comments at 27-28), even at times questioning how a proposed Common Clinical IT Platform will materially benefit patient outcomes. He does not explain why, if he felt the benefits to patient outcomes were not material, he supported spending what appears to be more than $1 billion of taxpayer dollars on a system for the VA. In his own comments, Dr. Kizer references his work at the VA by highlighting the largest deployment of an EHR anywhere to date, "dramatically improving quality of and access to care, reducing operating costs . . . ." (Kizer comments at 25)

Dr. Kizer's reference to OnePartner demonstrates his lack of understanding of the difference between a hospital operating system, which helps manage patient flow, revenue, physician orders, pharmaceutical management and all the concomitant systems that ensure full capture of patient data, analytics, standardization of care, patient safety mechanisms, and discharge planning and deployment versus a regional Health Information Exchange ("HIE"), which simply permits the sharing of certain bits of data about patients. The two are entirely different. OnePartner is not designed to do physician order entry or to manage patients through the entire process of care. The Parties' detailed plans for implementation of a Common Clinical IT Platform and the significant differences between an HIE and the Common Clinical IT Platform are described in detail in the Parties' July 1, 2016 Submission.[62] Dr. Kizer ignores the detailed plans and the significant differences between the Common Clinical IT Platform and an HIE described in this submission.

While the OnePartner HIE system is useful in reaching out to independent physicians, the system is limited in the data it can transmit. There is a significant difference between a regional

[61] Dr. Kizer uses his experience at the VA to suggest deployment could be a challenge. Given Dr. Kizer's apparent experience, his skepticism is justified. A recent GAO report demonstrated that after at least 18 years (which covers the span of time Dr. Kizer was at the VA), and billions of dollars spent, the VA and Department of Defense still have not figured out a way to share patient files across the agencies. Benjamin Krause, *Electronic Health Records Quagmire, VA, DOD Still Can't Share*, DISABLEDVETERANS.ORG, July 15, 2016, *available at* http://www.disabledveterans.org/2016/07/15/electronic-health-record-quagmire-va-dod-share/. In fact, a recent Commission on Care has advised Congress that the "VA should abandon its homegrown electronic health record system in favor of a commercial solution." Aisha Chowdhry, *Commission on Care, lawmakers want commercial HER for VA*, FCW, Sept. 8, 2015, *available at* https://fcw.com/articles/2016/09/08/va-commission-hearing.aspx. In contrast to the VA, the Parties here have experience with successful conversions.

[62] *See* Responses to Questions Submitted April 22, 2016, Exhibit 17 - 19.

health information exchange supported by a Common Clinical IT Platform and the current OnePartner system or any other HIE. The proposed Common Clinical IT Platform will be able to collect significantly more detailed patient information, including order entry, nurse notes and medication reconciliation, and will have additional analytical capabilities for population health management. (See Exs. 2 & 3.1 to Parties July 1, 2016 Submission)

Finally, Dr. Kizer's position seems to contradict national policy encouraging seamless IT technology and interoperability,[63] though he has not acknowledged any disagreement with this national policy. As pointed out, Wellmont has had a successful "big bang" conversion, and the Parties can benefit from Wellmont's experiences and related best practices.[64]

5. Dr. Kizer's Commentary On Increased Academic Research And Funding Is Insensitive To The Needs Of The Region And Demeans ETSU.

Dr. Kizer does not question the importance and benefits of the Parties' commitment of at least $85 million over ten years to develop and grow academic research opportunities, support post-graduate health care training and strengthen the pipeline and preparation of nurses and allied health professionals. Instead, he argues that the Parties have not provided sufficient detail about how the funds will be spent. However, the Parties have provided such detail in the Application (Application at 68-69), including creation of new specialty fellowship training opportunities, building an expanded research infrastructure, adding new medical and related faculty and attracting research funding (especially for translational research to address regional health improvement objectives). Further, the Parties have made clear that this commitment is in addition to what the Parties are already spending. As the Application points out, state and federal government research dollars often require local matching funds, and grant-making organizations such as the National Institutes of Health and private companies such as pharmaceutical companies want to know their research dollars are being appropriated to the highest-quality and resourced labs and scientists. (Application at 69) As evidence of their commitment to Academic Research and Funding in the region, the Parties convened the Research and Academics Community Work Group as one of four Community Work Groups organized in March, which had representation from the major academic institution in the region and which has for the first time begun to outline the structure and operation of a Collaborative Research Institute.[65]

The Parties believe the $85 million of investment provides the necessary seed money to create a growing research enterprise in the region. The objective is to hire faculty and develop a center that can attract research grants that can benefit the area. There is a tremendous opportunity to expand research in this region, given the vast health care disparities that exist here, and the historic underinvestment. As a combined system, there will be more than 100,000 discharges on a Common Clinical IT Platform, a physician-led Clinical Council and an academic partnership

[63] *See* Press Release, U.S. Dep't of Health & Human Servs., HHS Publishes a Roadmap to Advance Health Information Sharing and Transform Care, Oct. 6, 2015, *available at* http://www.hhs.gov/about/news/2015/10/06/hhs-publishes-roadmap-advance-health-information-sharing-and-transform-care.html.

[64] *See* Response #6 to November 22, 2016 Request for Information at V.B.2.

[65] *See* Application Exhibit 8.2 Attachment A (Charters of Work Groups) & Attachment B (Members of Work Groups).

with ETSU. This will be an attractive research investment for National Institutes of Health and other sources of funding.

Dr. Kizer's self-aggrandizing comments about his own research dollars within the University of California System are simply not relevant here, nor are they called for. ETSU is not the University of California, and Dr. Kizer's remarks are quite insensitive toward the efforts to invest in research in this region. This lack of concern for the difference between California and East Tennessee reaches beyond Dr. Kizer's lack of preparation or expertise to comment on the proposed merger. Unfortunately, it evidences a condescending attitude toward this region and the Parties' efforts to improve health care here by implementing programs similar to what Dr. Kizer strongly advocates.

Apparently, Dr. Kizer believes common EHRs are good for other parts of the nation, like the VA, but not for the people in this region. He believes population health efforts should involve organized care delivery systems elsewhere, but not in this region. He makes no mention of the fact that the Area Wage Index in this region is the second lowest in the United States, while it is among the highest where he resides, meaning the difference in reimbursement for his hospitals and the Parties' hospitals is substantial. He does not recognize the economic difficulty imposed on this region due to loss of jobs and an environment where alcoholism, drug abuse and mental illness have thrived. Instead, he suggests the Parties' local efforts to address these issues through the merger are ill-contrived, without providing any evidence to support his assertions and without even having reviewed much of the supporting information to the Application. He denigrates an $85 million investment in recruitment of faculty and retention of residencies as insignificant relative to his university in California, a comparison that is irrelevant. No new dollars will be provided in the region for investment in new research faculty without the merger, and $85 million will be invested with the merger. This is a stark difference.

Importantly, Dr. Kizer, like the other critics, proposes no solutions to the significant health care problems in this region. As Dr. Sargent, who has practiced here for 31 years, stated in the article from which Dr. Kizer and staff misquoted:

> **The merger is a once-in-a-generation opportunity for the region to assure that our health care is financially sustainable, clinically excellent, up-to-date and innovative, as well as provides access and needed services for all. If our region doesn't fight for and seize this opportunity, no one will do it for us…**
>
> **…There isn't an external benefactor out there that is going to ride in on a white stallion and solve our problems. If we're going to survive and thrive, it's up to us.**[66]

[66]Dale Sargent, *It's Up To Us: We Alone Can Seize Opportunities For Region's Health Care*, BRISTOL HERALD COURIER, Nov. 8, 2015, *available at* https://swvahealthauthority.files.wordpress.com/2016/09/41-bristol-herald-courier-it_s-up-to-us-we-alone-can-seize-opportunities-for-region_s-health-care.pdf.

VII. RESPONSE BY APPLICANTS

TO SUBMISSION OF

HOLSTON MEDICAL GROUP

A. Introduction

The Parties agree with the premise of HMG's comments to the Department that, "if properly regulated, the new health system could benefit the geographic service area." (HMG comments at 1) As detailed in the Application, the Parties will submit to appropriate regulation by the State of Tennessee as provided for in the Hospital Cooperation Act of 1993. Despite its acknowledgement of the New Health System's "potential for significant community benefits," (HMG comments at 1) HMG, which is a direct and significant competitor of the Parties, has expressed concern with respect to regulatory oversight, quality and cost, hospital reimbursement, size of the combined system's physician (employed and affiliated) workforce and the health information exchange. None of HMG's concerns reflects a reason to deny the COPA, and the benefits of the merger outweigh any disadvantages attributable to any reduction in competition likely to result from the merger.

B. The Hospital Cooperation Act Provides For Adequate Regulatory Oversight By The State

HMG's unsupported assertion that implementation of a Cooperative Agreement will result in indirect state regulation of the entire health care delivery system and related non–health care service providers in the Geographic Service Area overstates the impact of a merger between Wellmont and Mountain States, and HMG provides no evidence to support this claim. (HMG comments at 2) While the New Health System will play an important role in creating access to and providing high-quality care for patients throughout the Geographic Service Area, other large physician groups and other service providers, including HMG, will continue to operate outside the purview of the State's regulation of the New Health System and compete with the New Health System, for example, with respect to outpatient care services. The Parties do not influence HMG's referral patterns or HMG physician utilization of HMG-owned diagnostic, lab or other outpatient services from which HMG profits.

The New Health System will also continue to compete with HMG and its peer outpatient service providers for favorable contracts with payers to provide services to residents of the Geographic Service Area. In the Application, the Parties committed that the New Health System will not block HMG or any other provider[1] from contracting with a payer by agreeing to be the exclusive network provider to that payer. (Application at 28) HMG and other outpatient providers are not subject to any such restriction, meaning that not only is the New Health System not operating as a monopoly with respect to these services, but it may have placed itself at a competitive disadvantage. Furthermore, primary care physician groups typically play a more prominent role in risk-based contracting than hospitals do, and HMG is particularly well positioned with payers given its large group of employed primary care physicians in the area and its influential role within the Qualuable Accountable Care Organization ("ACO"). Primary care physicians tend to have substantial control over patient utilization, potentially more than hospitals. It is these groups, not large health systems, like the New Health System, that tend to drive the terms of risk-based arrangements.

[1]The term "provider" is used in this document to refer to both physicians and physician group facilities providing outpatient services (such as imaging or surgical procedures).

As an example of the high degree of influence HMG has over patient utilization, the Parties point to the implementation of "Extensivist" clinics by HMG and other physician groups. Such clinics are being deployed as an alternative to hospitalization, but are not currently regulated and will not be regulated under the COPA. The care site is lower cost and financially advantageous to physicians in a risk-based environment. Physicians are incentivized through their contractual arrangements with payers to reduce the use of inpatient hospitalization, or even outpatient "observation" status. Hospitals have limited influence over this model and continue to contend with the cost of duplicative inpatient and hospital capacity that is exacerbated as physicians are responding to payers' financial incentives to decrease hospitalizations. HMG has enormous market power to influence hospital utilization and to shift the location of care, and it does so. This substantial power and ability to shift patients to outpatient care will not change with the proposed merger.

Based on the significant influence that large physician groups like HMG will continue to have with patients and with payers in the event of a merger between Wellmont and Mountain States, the Parties dispute HMG's characterization of the New Health System as a "monolithic, region-wide, monopolistic structure." (HMG comments at 2) While the New Health System will operate the majority of inpatient beds in the Geographic Service Area, approximately 25 percent of the area residents will continue to seek inpatient services outside the New Health System, and there is and will continue to be a robust and competitive market for outpatient services. Moreover, with regard to physicians, according to the chart included in HMG's comments, the majority of physicians in the Geographic Service Area (75%) are independent physicians and will remain so after the merger. (HMG comments at 3) HMG's control of a large segment of the patient population along with commitments that constrain the New Health System's competitive behavior toward physician groups will ensure that the New Health System will act competitively.

HMG correctly notes that the New Health System's share of total physicians is low, yet asserts that there are substantial disadvantages for independent physicians because they are organized into several groups rather than a few groups that are as large as the employed New Health System's physicians. However, no basis is provided for asserting that physician groups of 50-100 physicians in the Geographic Service Area are unable to provide outstanding care and participate actively in the delivery of care in outpatient facilities and physician offices, as well in inpatient services. In fact, many of the investments and commitments made by the New Health System are ones that benefit these physicians indirectly and their patients.

Based on unfounded concerns of a "monopolistic" New Health System, HMG recommends a "robust regulatory authority" that is "locally based, collaboratively structured, with authority to orchestrate dialogue within the [Geographic Service Area] and make enforceable decisions," but it is not clear what kind of regulatory body HMG is proposing. (HMG comments at 2) The Parties submit that the law does not provide for delegation of the State's regulatory authority to any other entity. However, the Parties do wish to emphasize their intent to develop a collaborative relationship with the organized and independent physician community, especially with respect to the ongoing transition to value-based purchasing that all are undertaking and also with respect to establishment of an Accountable Care Community. The Parties desire to identify health improvement priorities for the region and align incentives with physician groups so that all providers can be a part of successfully "moving the needle." In this

regard, the New Health System will be governed by a local board, composed of a variety of business leaders from both large and small companies representing purchasers of health care in the region, independent physicians and the President of East Tennessee State University.

C. The Merger Will Not Decrease Quality, Increase Cost Or Limit Access To Value-Based Care

The Parties disagree with HMG's statement, relying wholly on the assertions by staff that the Parties contend are false, that the merger will reduce quality of care and raise costs and have the effect of preventing patients and providers, including independent physicians, from participating in innovative, value-based health care delivery models. (HMG comments at 2-3)

HMG does not present any analysis related to its concerns about price increases as a result of the merger, instead summarily citing staff's concerns and providing no detail in support. The Parties agreed in the Application to reduce existing commercial contracted rate increases by 50 percent in the first contract year following the first full year after the formation of the New Health System and to cap increases to negotiated reimbursement rates in subsequent years. (Application at 46-47) HMG's comments do not address why it believes the proposed price controls are inadequate.

Additionally, HMG does not compare the likely pricing effects of the merger with the impact that one or both of the Parties undergoing an out-of-market merger would have on pricing. One recent study found that net reimbursement rates at hospitals on average "increase by about 17 percent after joining an out-of-market hospital system with some specifications suggesting even larger effects."[2] While this study did not assess pricing effects of in-market mergers, its findings indicate that if Wellmont or Mountain States were to merge with a health system in another market, that merger could result in significant price increases. FTC officials have commented publicly, "We also hear growing concern that provider consolidation in non-overlapping product or geographic markets may lead to higher prices."[3]

When considering the pricing effects of the Parties' merger, it is a mistake to use the status quo as a baseline for comparison, as HMG seems to, because if the Parties do not merge, one or both will likely be acquired by an out-of-market system. Acquisition by an out-of-area system is less likely to achieve the substantial efficiencies from the in-market combination of Wellmont and Mountain States, and as a result will not provide the synergies that fund investments and activities, including electronic medical records, technology and other programs that will benefit the community as well as independent physicians who will have the benefit of access to and use of these tools for their own and their patients' benefit. There may be upward pressure on costs and hence pricing from continued duplication and likely reduced inpatient

[2]Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, RAND J. ECON. (forthcoming August 13, 2016), *available at* http://www.johnsoncitypress.com/.media/5/2016/12/09/66a04d6f-d97f-4aef-837e-e8712ca2806e.pdf.

[3]Chairwoman Edith Ramirez, Retrospectives at the FTC: Promoting an Antitrust Agenda, ABA Retrospective Analysis of Agency Determinations in Merger Transactions Symposium (June 28, 2013), *transcript available at*: https://www.ftc.gov/sites/default/files/documents/public_statements/retrospectives-ftc-promoting-antitrust-agenda/130628aba-antitrust.pdf.

utilization across the two health systems absent this merger. The likely impact on pricing from an out-of-market merger is the relevant comparison to the pricing effect of the proposed merger.

With respect to quality, two compelling drivers reinforce the Parties' mission-driven commitment to providing high-quality care: transparency and reimbursement impact. In the Application, the Parties committed that the New Health System will publicly report its performance on a broad array of quality measures. (Application at 110, Table 11.12) Between the New Health System's unique reporting under the Application and existing quality reporting by the Centers for Medicare and Medicaid Services ("CMS"), patients will easily be able to tell how well the New Health System is performing against its own commitments and against other health systems in the region. This broad and deep transparency will create a layer of accountability to ensure that quality does not slip. Additionally, reimbursement incentives and penalties tied to a host of quality measures, from care process to readmissions, now play a major role in driving quality for all providers, including hospitals. The federal government's commitment to alternative payment models, and the increasing implementation of these models by commercial payers, serves as evidence that reimbursement incentives drive quality.

HMG provides no compelling evidence or logic to support the claim that hospitals with a high share or that obtain increased share from a merger have relatively lower quality. There are numerous examples of hospitals and health systems that receive high rankings by, e.g., U.S. News and World Report as a Top 100 hospital, by other well-regarded organizations that award quality and by CMS on various quality measures. Sole community providers can be high-quality hospitals. Relatively low share is not a predictor of higher quality. In fact, the Parties have provided evidence to support that Mission Health's recognition as one of the highest-value health systems in the nation, multiple-year recognition as one of the top 100 hospitals in America by Truven Health Analytics and recognition as one of the top 15 health systems in the nation by Truven Health Analytics, implies that after 20 years operating as a merged system under a COPA, quality was, in fact, not impaired. HMG's argument here amounts to nothing more than second-guessing of Tennessee's sovereign policy to supplant competition with regulation for qualified health care mergers and should be ignored.

The Parties have demonstrated their commitment to providing high-quality care in the Geographic Service Area by committing to spend $75 million on population health and invest $140 million in expanded community-based mental health and addiction recovery services, pediatric specialties and other ways for patients to access care. (Application at 4-5) The Parties understand that access to services beyond traditional medical care has a direct impact on overall quality and patient outcomes, and through the Parties' commitments tied to the merger, the merger will directly improve quality by increasing patient access across the continuum of care and across the region.

The Parties also disagree with the implication that the merger will limit patients' and providers' opportunities to participate in innovative value-based payment models. Because physicians, and in particular primary care physicians, play an integral role in the care patients seek and referrals for that care, alternative payment models are largely structured around physicians rather than hospitals. The emphasis on physicians in the transition to value-based payment means that large physician groups, including HMG, will have ample opportunity to participate in, and involve their patients in, innovative reimbursement models regardless of

whether the merger between the Parties occurs. As an example, because risk-based contracts and Medicare's Shared Savings Programs are based on patient attribution to physicians, the success or failure of an ACO (including physician-owned Qualuable and Mountain States–owned Anewcare) depends upon which organized group physicians choose to join.

D. Hospital-Specific Reimbursement Rates Are Irrelevant To Consideration Of The Merger

HMG presents the flawed proposal that "the delta between the hospital-based reimbursement model and the independent reimbursement models should serve as one of the benchmarks for success of the merger." (HMG comments at 3) This suggestion is baseless, and, in any case, it is infeasible because the Parties do not control hospital reimbursement policy set by CMS or commercial payers. HMG appears to seek policy changes that are completely independent of the merger, and also fails to note that the Parties' overall reimbursement rates will be regulated to increase at reasonable rates. Furthermore, HMG fails to consider the policy reasons for higher hospital reimbursement rates, including the obligation unique to hospitals to provide care for Medicaid beneficiaries and the uninsured. HMG is not required to see patients who are on Medicaid or uninsured, while hospitals are. For these reasons, the Parties contend that HMG's comments with respect to hospital reimbursement are without merit.

E. The Merger Will Not Advantage New Health System Physicians Or Harm Professionalism

HMG incorrectly asserts that New Health System's 737 employed physicians would constitute a single giant medical group with "cost efficiencies, internal referral patterns, marketing power and other benefits that the remainder of the physician community could never match." (HMG comments at 4) This view dramatically oversimplifies the relationships among hospital-employed physicians, who function cohesively within their specialties but not as a unified multi-specialty group. Furthermore, HMG ignores the differences between "hospital-based" physicians (such as emergency room physicians), primary care physicians in less rural communities, specialists in higher acuity specialties and primary care physicians and specialists in rural communities. It is misleading to "lump" physicians in all of these categories into one number in order to suggest there is market power that does not, in fact, exist. Even so, the vast majority of physicians are independent and the size of individual groups is not a meaningful indicator of market power.[4] In the health care marketplace, primary care physicians are uniquely positioned to influence patient flow and service utilization. The majority of primary care physicians in the Geographic Service Area today are independent, and the majority of primary care physicians will be independent after the merger.[5] The same is true of physicians in nearly all specialties, with only limited exceptions, and even in these specialties there are competing physicians.[6]

[4]We note as well that any alleged exercise of market power in terms of increased rates is constrained by the rate cap commitments on physicians.

[5]*See* Responses to Questions Submitted April 22, 2016, at Updated Exhibit 6.1E (July 25, 2016), *available at* http://tn.gov/assets/entities/health/attachments/WHS-MSHA_April_22,_2016_Response_2.pdf.

[6]*Id.*

The Parties do not believe that the size of the New Health System creates an inappropriate advantage for its employed physicians, but have nevertheless stated in the Application that they expect the New Health System to employ physicians "primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding."[7] The Parties have committed to prioritize recruitment into existing independent medical practices, as opposed to using employment models, with the exception being underserved areas where employment is the only reasonable way to ensure the needs of the community are met. Limiting its own physician recruitment and assisting independent physician groups with recruitment places the New Health System at a disadvantage with respect to the development of value-based payment arrangements with payers. Even if the New Health System's size created a competitive advantage for its physicians (which, as previously stated, the Parties strenuously contend that it does not), the New Health System's willingness to interact with the independent physician community in a way that disadvantages its own physician practice negates any such advantage.

HMG's unsupported assertion that the Parties' merger "will inflict irreparable damage to independent professionalism in exchange for corporate efficiencies" is also misguided. (HMG comments at 4) First, while the Parties respect the corporate practice of medicine doctrine and its role in Tennessee's health care delivery system, the State has determined that hospital employment of physicians is beneficial enough for Tennessee's residents to merit a statutory exception.[8] HMG's belief that "there are too many exceptions to [the corporate practice of medicine doctrine's] strictures" is irrelevant and unsupported. (HMG comments at 4)

Second, HMG's conception of "independent professionalism" is subjective, and the Parties believe physicians currently employed by Wellmont and Mountain States would take issue with the assertion that because they are employed by a hospital owned by non-physicians, they are somehow compromised in their professionalism. HMG offers no support for its statement that hospital employment of physicians, which the State of Tennessee has determined merits an exception to the otherwise-observed corporate practice of medicine doctrine, "undermines the physician-patient relationship by imposing non-physician corporate governance over the responsibilities of highly trained professionals." (HMG comments at 4) Additionally, HMG does not examine the ways in which the Parties' independent medical staffs assure that physicians' judgment in professional matters operates free from corporate interference.

Finally, HMG ignores the fact that virtually all of the physicians who would be employed by the New Health System are already employed by Wellmont or Mountain States. HMG fails to articulate why employment by the New Health System would be any different or more harmful than these physicians' current employment arrangements with regional health systems. There is no basis in HMG's comments for concluding that changing the upstream corporate parent of these physicians' current corporate employers would result in "irreparable damage to independent professionalism."

[7]Application at 44.

[8]Tenn. Code Ann. § 63-6-204(f)(1).

F. The Merger Would Allow The Parties To More Fully Engage In HIE Through A Common Clinical IT Platform

The Parties are dedicated to sharing data and advancing patient care, patient experience and lower cost though population health management methods and interoperability best practices. This objective will be a guiding principle for the New Health System and will be realized by deploying a system-wide Common Clinical IT Platform with fully integrated population health management tools, analytics and interoperability relationships once the merger is complete.

The health information exchange OnePartner is a for-profit entity owned by HMG and its physician owners, which casts doubt on HMG's motives for asserting that "robust and complete participation by the New Health System in OnePartner [is] a lynch-pin in supporting the continued existence and success of independent physicians and other outpatient service providers." (HMG comments at 4) The Parties agree that the free exchange of health information is critical to providing high-quality health care across the Geographic Service Area, which is why the Parties committed in the Application that the New Health System will "participate meaningfully in a health information exchange open to community providers" and 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."[9] Wellmont and Mountain States both currently participate in OnePartner, and the Parties intend to continue providing their electronic medical records ("EMR") data to OnePartner after the merger, meaning HMG and other independent physicians will have the same access to the New Health System patients' data that they have to Wellmont and Mountain States patients' data today. The Parties respectfully submit to the State, however, that they should not be required to participate in any particular health information exchange—particularly when the party requesting such participation stands to benefit financially. While the State has no compelling interest in forcing the Parties to engage with a private, for-profit company, the Parties have committed to meaningful participation with the HIE, including utilization of the data, so long as the HIE is cost-effective and so long as other, more advanced mechanisms for sharing of data don't become more practical.

HMG has recommended that the COPA Index include measures tracking a variety of activities related to the exchange of health information, but the Parties assert that their current commitments in the Application are sufficient to ensure that the region and its patients have the benefit of a health system that effectively utilizes technology to ensure the highest quality care in a variety of settings. HMG states that implementation of value-based care models "requires seamless coordination of care across all providers," (HMG comments at 4) which the New Health System's Common Clinical IT Platform (the establishment of which is an additional commitment in the Application (Application at 55)) will make possible. All New Health System patient information will be on the same EMR system, and a link to access the data in the New Health System EMR, including data brought into the New Health System EMR from other regional providers' EMRs, will be available in all independent physician offices. This is another example of how the commitments made by the Parties will benefit employed as well as

[9]Application at 55.

independent physicians, with a common goal and incentive to improve health and outcomes in the Geographic Service Area.

HMG also warns that the New Health System's new IT platform must support bi-directional data exchange, or it "will promote barriers to data sharing and provider workflow," (HMG comments at 4) but the Common Clinical IT Platform will allow bi-directional data exchange with the EMR. OnePartner's bi-directional functionality, however, is currently limited to sharing information with other HMG information systems and does not have the capability of transferring data into other providers' EMR systems. The comments from HMG also suggest that the New Health System should be required to share "[t]he actual value of dollars spent by the Applicants for health information exchange that benefit both employed and independent providers of medical services." (HMG comments at 5) Notably, OnePartner is the only vendor with whom the Parties share information that charges any fee. The New Health System's information exchange features will be embedded into the features of its Common Clinical IT Platform, enabling the New Health System to exchange health information with other providers at no additional cost, except the cost of OnePartner's service.

G. Conclusion

While the Parties appreciate and share HMG's concern for maintaining and enhancing high-quality, low-cost care for the region, HMG's role as a competitor of both Wellmont and Mountain States calls into question the motives for its comments. Following the merger, there will still be more independent primary care physicians and more independent physicians in many specialties than those employed by the New Health System, and HMG and other independent providers will continue to offer a robust suite of outpatient services. Based on the analysis above, the Parties submit that HMG's comments, which support that organization's own competitive interests, do not present any reason to deny the Parties the COPA and decline its benefits, which even HMG acknowledges could be "significant," to a region badly in need of a collaborative approach to investing in population health.

VIII. CONCLUSION

The COPA provides a unique opportunity for Tennessee to implement a public policy directed toward improving the cost, quality, and accessibility of health care services in Northeast Tennessee to levels that have not been attained and are likely unattainable under the competitive market status quo. By the mechanism of a COPA, for Wellmont and Mountain States would be authorized to merge in order to become an integrated and efficient single entity, subject to 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.

The comments opposing the merger fail to consider the specific and significant health care challenges that this region faces and that have prompted the Parties to submit their Application for a Cooperative Agreement. The comments also do not explain how the competitive market status quo from which these challenges emerged is a better approach for solving them. Commenters opposing the merger seek to apply a hypothetical construct of federal antitrust policy that is decidedly different from and inapposite to the sovereign Tennessee policy expressed through the Hospital Cooperation Act. They argue that an antitrust approach is preferable (and could work anywhere) - whether in urban or rural areas, regardless of health and economic conditions, and without the enforceable commitments that are available only in a cooperative agreement. The comments further disregard the substantial new investments required to address the region's health needs and improve access, quality, and cost of care delivery. The commenters fail to offer any realistic alternatives that would offer the same level of commitments as the proposed merger. Finally, the comments fail to recognize that Tennessee has specifically implemented its express public policy whereby mergers that may reduce competition can be regulated to limit sharply any risk of potential disadvantages, while enabling the beneficial attributes of substantially greater importance to flow to the community.

For the many reasons stated herein, the Department should reject the arguments submitted by the staff, Amerigroup, the Academics, Dr. Kizer, and HMG.

IX. EXHIBITS

LIST OF EXHIBITS

Exhibit Number	Description
Exhibit III.A	Comments on Twitter by Professor Gaynor
Exhibit III.B	Revised Plan of Separation between the Parties
Exhibit VI.A	Curriculum Vitae of Dr. Dale Sargent

EXHIBIT III.A

Comments on Twitter by Professor Gaynor

Tweets with replies b ×

Twitter, Inc. [US] https://twitter.com/MartinSGaynor/with_replies

Home Moments Notifications Messages Search Twit

(((Martin Gaynor))) Retweeted

Karson Mahler @KarsonMahler · Jul 6

Ok WV, but don't complain to HHS when your premiums go up. The ACA doesn't mandate dumb competition policy. @SavageLucia @FTC @MartinSGaynor

1 3

(((Martin Gaynor))) @MartinSGaynor · Jul 6

Just one or two...

> **Altarum_CSHS** @Altarum_CSHS
>
> Hope you left a few problems unsolved for our July 12 meeting eiseverywhere.com/ehome/index.ph… Baicker, Chandra, etc., etc. twitter.com/MartinSGaynor/…

2

(((Martin Gaynor))) @MartinSGaynor · Jul 6

Ugh. WV legislators, governor should be ashamed of themselves (if they had any shame).

> **Dan Gorenstein** @dmgorenstein
>
> So this means 11th hour move by hospitals, with assist from state lawmakers and Governor, all went according to plan twitter.com/lschencker/sta…

2

Tweets with replies b ×

Twitter, Inc. [US] https://twitter.com/MartinSGaynor/with_replies

Home Moments Notifications Messages Search Twitter

(((Martin Gaynor))) @MartinSGaynor · Jul 6

Monopoly wins, patients lose. WV state government fails its citizens. #merger #healthcare #antitrust #ABASAL modernhealthcare.com/article/201607…?

Modern Healthcare

BREAKING: FTC drops challenge of West Virginia …

The Federal Trade Commission is dropping its challenge of a West Virginia hospital merger in light of the passage of a state law meant to protect the deal fr...

modernhealthcare.com

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EXHIBIT III.B

Revised Plan of Separation
between Wellmont Health System and Mountain States Health Alliance

Revised Plan of Separation
between
Wellmont Health System
and
Mountain States Health Alliance

Pursuant to Grant of Certificate of Public Advantage
By the Tennessee Commissioner of Health

This Revised Plan of Separation ("the Revised Plan") is prepared as part of the application for Certificate of Public Advantage ("COPA") submitted jointly by Wellmont Health System and Mountain States Health Alliance (collectively "the Parties") to the Tennessee Department of Health ("the Department"). The Revised Plan is intended to set out the process by which the Parties would effect an orderly separation of the new, integrated health system to be created under the COPA (the "New Health System") in the event that the Department determines that it is necessary to terminate the COPA previously granted to the Parties, as set forth in T.C.A. section 68-11-1303(g).

1. Overview. The purpose of this outline is to comply with Tenn. Comp. Rules & Regulations 1200-38-01-.02(2)(a)(17). The Revised Plan will be described in two scenarios: the "Short-Term Period" (0 to 18 months) and the "Long-Term Period" (after 18 months).

2. Short-Term Period Plan of Separation. (0 to 18 months post-closing)

   A. Overview. Re-establish a competitive dynamic by returning assets and operations to the control of the contributing party.

   B. Assets Held Separate. Mountain States and Wellmont will not, during the Short-Term Period, transfer to the other, or to the New Health System, any Material Operating Assets held by either Mountain States or Wellmont prior to the affiliation. For purposes of this commitment, "Material Operating Assets" shall mean those assets that exceed 10% of the New Health System's total assets or roughly $300 million. Assets used in providing support services to Mountain States and Wellmont may be transferred as appropriate to effect the integration and achieve cost savings and performance improvement.

   C. The Process. Upon written notice from the Department that the COPA has been terminated, the following would occur:

      (1) Preservation of Business. The New Health System will take all actions necessary to maintain the independent viability and competitiveness of Mountain States and Wellmont pending separation.

      (2) Governance. The New Health System's Board of Directors will oversee the plan of separation to insure that the plan is successfully implemented, minimizing to the extent possible disputes between the separating entities and

disruptions in operations. Upon implementation of the plan of separation, the New Health System will be removed as member of Mountain States and Wellmont. Mountain States and Wellmont will return as the parent corporations of the pre-combination entities:

a) Mountain States. Mountain States directors will resign from the Wellmont Board and the New Health System Board. Mountain States directors will appoint additional directors to the Mountain States Board.

b) Wellmont. Wellmont directors will resign from the Mountain States Board and the New Health System Board. Wellmont directors will appoint additional directors to the Wellmont Board.

(3) Management.

a) The Executive Chair/President of the New Health System will be named the Chief Executive Officer of Mountain States.

b) The Chief Executive Officer of the New Health System will be named the Chief Executive Officer of Wellmont.

c) Mountain States and Wellmont will appoint other executive officers of the respective corporations pursuant to established corporate procedures.

d) Clinical Managers will be assigned to the Mountain States/Wellmont Clinical Site that is the Manager's principal place of service.

(4) Financial. Mountain States and Wellmont will become separate financial enterprises.

a) Debt. Any debt issued by the New Health System will be allocated to Mountain States and Wellmont based upon the proportion of pre-merger debt that each brought to the merger, except that if the proceeds of any debt issued by the New Health System have been used to benefit a facility or facilities (e.g, debt proceeds used to expand physical plant), such debt will be allocated to the entity which receives that facility in the separation.

b) Reserves. The cash and marketable securities of the New Health System will be separated between Mountain States and Wellmont in proportion to the original contribution at closing.

(5) Employees. The New Health System employees will be assigned to their principal place of business. Clinical employees will be assigned to the

Mountain States/Wellmont site that is the employee's principal place of service.

(6) Employee Benefits. To the extent employee benefit plans have been combined, a plan of separation addressing employee benefits will be submitted. Each of Mountain States and Wellmont will be free to change or modify plans under separation. Mountain States and Wellmont will provide all legacy employees with credit for their New Health System service.

(7) Clinical Services. During the Short-Term Period, the New Health System expects the consolidation of any significant clinical services to be limited. To the extent clinical services are combined, a plan of separation addressing clinical services, including a transition services agreement, will be submitted to the Tennessee Department of Health for information prior to such combination.

(8) Information Technology. During the Short-Term Period, the New Health System will develop a combined approach to information technology. While planning and implementation are expected to begin, it is not anticipated that the Common Clinical IT Platform will be fully implemented in the Short-Term Period. Mountain States/Wellmont will each establish separate information technology services as part of the plan of separation. Transition services agreements will be utilized to assure no interruption in operations for Mountain States or Wellmont post-separation.

(9) Payers. During the Short-Term Period, the New Health System expects to negotiate payer agreements consistent with the terms and provisions of the COPA. In the event of any separation of the New Health System during the Short-Term Period, both Mountain States and Wellmont will honor the provisions of the New Health System payer agreements for the balance of any base term (without renewals). If any payer wishes to modify or replace its New Health System payer agreement, Mountain States and Wellmont will negotiate in good faith to reach a mutually acceptable modified or new agreement. All future payer agreements will be negotiated separately by Mountain States and Wellmont.

(10) Physicians. During the Short-Term Period, the New Health System expects to plan, but not execute, a combination of its physician enterprises. To the extent any physician services are combined, a plan of separation addressing physician services, including actions to return physician and other clinic employees to the Mountain States or Wellmont entity that was his or her employer at the closing, will be submitted to the Tennessee Department of Health for information prior to action. Hospital-based physician contracts, such as radiology, pathology, anesthesia, hospitalists,

and emergency medicine shall be assigned to the site of service. Mountain States and Wellmont shall honor the physician contracts for the remainder of the base terms (without renewals).

(11) Dissolution. Once Mountain States and Wellmont no longer require support services from the New Health System, the Board of Directors of the New Health System will follow the procedures for voluntary dissolution of the New Health System as provided by Tennessee law.

3. Long-Term Period Plan of Separation. (after 18 months post-closing)

A. Overview. The Long-Term Period plan of separation would be implemented if the Department terminates the COPA after determining that the benefits of the merger no longer outweigh the disadvantages by clear and convincing evidence. Due to the difficulty of predicting the health care environment in the long term, the Long-Term Period plan of separation of necessity is a description of a process for deciding how to separate the assets and operations of the New Health System.

B. The Process:

(1) Upon receipt of written notice from the Department that the COPA has been terminated, the New Health System will retain a qualified consultant ("the Consultant").

(2) The Consultant will assist the New Health System in complying with the written notice that the COPA has been terminated by analyzing competitive conditions in the markets subject to the Department's written notice and identifying the specific steps necessary to return the subject markets to a competitive state.

(3) The New Health System will submit a plan of separation to the Department (the "Proposed Plan). The Proposed Plan will address each of the substantive elements required of a Short-Term Period plan of separation and will be accompanied by a written report from the Consultant concerning the suitability of the Proposed Plan in addressing the competitive deficiencies that resulted in the termination of the COPA.

(4) The Proposed Plan shall be submitted within 180 days of receipt of written notice from the Department that the COPA has been terminated. The Proposed Plan shall include a timetable for action which shall be approved by the Department.

C. Upon the Department's approval of the Proposed Plan (or of any plan that contains revisions thereto) (the "Final Plan"), the New Health System will implement the Final Plan within the timetable prescribed in the Final Plan.

D. The Final Plan will provide that the Department may require that an independent third-party health care expert serve as a monitor ("the Monitor") to oversee the

process of implementing the Final Plan. The New Health System will pay the fees and expenses of the Monitor.

4. Non-Exclusive Plan. To the extent the Parties or the New Health System reasonably determines (based upon the current facts and circumstances) that a competitive dynamic may be restored in another, more efficient or effective means, the Parties or the New Health System may submit a new plan of separation different from the pre-submitted plan. In such event, the amended plan of separation must receive the Department's approval prior to its implementation.

5. Annual Update. Department regulations provide that the plan of separation be updated annually. The annual update will address each of the following elements as appropriate and possible in light of the then existing facts and circumstances: (a) Governance, (b) Management, (c) Financial Separation, (d) Employees, (e) Employee Benefits, (f) Clinical Services, (g) Information Technology, (h) Payers, and (i) Physicians.

EXHIBIT VI.A

Curriculum Vitae of Dr. Dale Sargent

CIRRICULUM VITAE

Jeffrey Dale Sargent, M.D.

Birth:	May 22, 1954, Bluefield, West Virginia
Citizen:	U.S.A.
Social Security Number:	*** ** ****
Wife:	Joneen Maxwell Sargent
Children:	Millie and Max

EDUCATION

Grad. 1972	Richlands High School, Richlands, Virginia Honors: Beta Club
1972-1975	King College, Bristol, Tennessee BS 1986 Honors: O.L. White Science Scholarship 2nd in class - Freshman Year 1st in class - Sophomore Year 1st in class - Junior Year
1975 -1979	Medical College of Virginia, Richmond, Virginia Degree: Doctor of Medicine, May 1979 Honors: 2nd in class - Freshman Year Neuroscience's Award Alpha Omega Alpha
1979 - 1982	Residency, Internal Medicine, North Carolina Memorial Hospital, Chapel Hill, North Carolina
1982 - 1984	Fellowship, Pulmonary Medicine, University of North Carolina School of Medicine, Chapel Hill, North Carolina
1984 - 1997	Private Practice of Pulmonary and Critical Care Medicine, Bristol Regional Medical Center, Bristol, Tennessee
1994	Chief of Staff, Bristol Regional Medical Center
1993 - 1997	Medical Director of Quality Improvement and Utilization Management Bristol Regional Medical Center
1997 - 2004	Executive Vice President of Medical Affairs, Wellmont Health System, Kingsport, Tennessee
2004-2005	Chief Medical Officer, Wellmont Health System, Kingsport, Tennessee

2005- 2007 Hospitalist, Kingsport Consultants, Holston Valley Medical Center, Kingsport, Tennessee

2007- 2009 Pulmonary and Critical Care Medicine, Pulmonary Associates of Kingsport, Kingsport, Tennessee

2009-2011 Chief Medical Officer, Wellmont Health System, Kingsport, Tennessee

2011-2014 Hospitalist, Lonesome Pine Hospital, Big Stone Gap Virginia; Mountian View Regional Medical Center, Norton, Va.

2011-2014 Instructor for Inpatient Medicine Service, Osteopathic Family Medicine Residency, Norton ,Va

2014 -2015 Hospitalist and co-medical director, WMA Hospitalist program, Bristol Regional Medical Center, Bristol, Tn.

2015 – Present Hospitalist and system medical director of hospitalist programs for Wellmont Health System, Kingsport, Tn.

CERTIFICATION

American Board of Internal Medicine - September 1982- present
American Board of Internal Medicine (Pulmonary Diseases) - November 1984-present
American Board of Internal Medicine (Critical Care) - 1987 -2007
Certified B Reader, 1986, Recertified 1990 and 1994

RESEARCH

Involvement of the Lung in Patients with Polymyositis
Migration of Neutrophils Across Tracheal Epithelium

SOCIETIES

American College of Physicians - Associate
American College of Chest Physicians - Fellow

PUBLICATIONS

Sargent, Fairman, Sessions - "Pulmonary Vasculitis Complicating Ulcerative Colitis", Southern Medical Journal, Vol. 78, No. 5, p. 624, 1985

Sargent, Mease, Howard - "Viral Pneumonitis in a Compromised Host: Is An Aggressive Diagnostic Approach Indicated?" North Carolina Medical Journal, 1985

Sargent, Nowiski, Zimmerman - "An Experience with Clinical Case Management and Clinical Pathways", Quorum Health Resources Financial Services Newsletter, April 1995

Clare, Sargent, Moxley, Forthman - "Reducing Health Care Delivery Costs Using Clinical Paths: A Case Study on Improving Hospital Profitability", J. Health Care Finance 1995: 21(3) 48-58

Sargent – "Good-bye, my friend", American Journal of Hospice & Palliative Care, Volume 20, Number 4, p. 311, July/August 2003

LICENSING

Tennessee: MD ******
Virginia: