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January 17, 2017

BY EMAIL (erik.bodin@vdh.virginia.gov) ONLY
Mr. Erik O. Bodin, Director
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1485

Re: Request for Additional Information – Response # 3

Dear Mr. Bodin,

In an effort to facilitate a more streamlined approach toward the delivery of responses to the questions received from your office on December 22, 2016, our firm has transitioned to the use of a secure file sharing platform that will aid in the management of and the ease of access to shared information. At present, the material shared on this platform consists of public information, Mountain States Health Alliance proprietary information, and Mountain States Health Alliance / Wellmont Health System joint proprietary information. Wellmont Health System proprietary information will be submitted separately. We think this will be more user-friendly for you and your staff.

Response # 3, and all subsequent responses thereafter, unless circumstances arise that require a change in the delivery system, will be provided to your office using the Citrix ShareFile platform. You will receive a separate email from Citrix ShareFile that will provide a link to access the information along with a unique username and temporary password.

Please contact me if you have any difficulty or questions in accessing the Citrix ShareFile platform. As permitted under Virginia Code § 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), the material that the parties believe to be proprietary is clearly marked and submitted in separate electronic files for confidential treatment.

Responses to the following questions are submitted as part of Response # 3:

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Additional responses will be provided as soon as possible. Please let me know if you or your staff has any questions related to the enclosed documents.

Sincerely,

Jennifer L. McGrath

cc: Peter Boswell
Allyson K. Tysinger

RESPONSE #3

TO QUESTIONS

SUBMITTED DECEMBER 22, 2016

BY

VIRGINIA DEPARTMENT OF HEALTH

IN CONNECTION WITH

APPLICATION FOR LETTER AUTHORIZING COOPERATIVE AGREEMENT

Pursuant to Virginia Code § 15.2-5384.1

and the regulations promulgated thereunder at 12VAC5-221-10 *et seq.*

Submitted by: Mountain States Health Alliance

Wellmont Health System

Date: January 17, 2017

V.C.2.

2. **Provide the revenues and expenses for the two (2) year historical baseline period, YTD, and the five (5) year forecast period for the core research budget. Detail how the core research budget will be financed. Clearly demonstrate whether the investments proposed are incremental or lump sum.**

JOINT RESPONSE:

As explained in the Application, the Parties have committed to reinvesting savings over the next ten years including $85 million to develop and grow academic and research opportunities. Should the Cooperative Agreement be granted, the investment in research and training set forth in the Application represents a net increase of $85 million in aggregate over the past research and training investment for the ten year period following the creation of the New Health System.

The proposed merger provides funds generated through merger efficiencies, some of which the Parties will invest in the development of research and academic enhancement to bring specific health care and economic benefits to the community. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, expanded services and training can also contribute to the economic vitality of the area as well as the improved ability to attract medical professionals and business endeavors, thereby benefiting the communities with overall health and economic wellbeing.

Strategically, a major part of the New Health System's emphasis will be on the development of academic research infrastructure and personnel which is needed to attract additional research funding from national sources—specifically in the area of translational research. The New Health System intends to allocate resources to priority research projects identified by the New Health System and academic partners in pursuit of this goal. Translational research projects that are focused on rural health care, population health management, health care transformation, and community health improvement will offer important insights to inform the New Health System's overall efforts in the region and to create national models.

Further, the Parties will focus on developing the academic infrastructure to ensure effective training for the next generation of health professionals that are needed to address the health care needs of this region. This will require a program gap analysis and the formation of program development plans. In addition, the Parties will work to identify fellowship training opportunities to support the regional base of sub-specialty physicians along with collaboration where professors and research leaders can work together to close gaps in regional specialty services or provide clinical oversight. The Parties expect that an offshoot of these comprehensive efforts will be the development of new medically and technically oriented businesses in the region, and the Parties plan to work with municipalities and economic development agencies to help incubate these opportunities and attract new opportunities to the region to support the regional economy.

Additional detail on the spending associated with academic and research opportunities is provided in the annual estimate of reinvestment from efficiencies provided below. Decisions on apportionment of the funds to academic and research programs will be made with academic and research partners.

	Academic and Research Reinvestment from Efficiencies Generated by the Merger
Year 1	*3,000,000*
Year 2	*5,000,000*
Year 3	*7,000,000*
Year 4	*10,000,000*
Year 5	*10,000,000*
Year 6	*10,000,000*
Year 7	*10,000,000*
Year 8	*10,000,000*
Year 9	*10,000,000*
Year 10	*10,000,000*
TOTAL	***$ 85,000,000***

MSHA RESPONSE: MSHA does not forecast for the core research budget and is, therefore, unable to provide five-year forecast information. All other requested information is provided.

MSHA believes that **Exhibit _C-2A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit C-2A MSHA Research Revenues and Expenses – **PROPRIETARY**

WHS RESPONSE: WHS does not forecast for the core research budget and is, therefore, unable to provide five-year forecast information. All other requested information is provided.

WHS believes that **Exhibit _C-2B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit C-2B WHS Research Revenues and Expenses – **PROPRIETARY**

V.C.7.

7. Describe the strategy by which the NHS will offer research benefits to Virginia residents greater than already offered at other Virginia academic medical centers?

JOINT RESPONSE: Currently, academic research opportunities in Southwest Virginia are very limited in scope and few academic medical center research opportunities extend into the region. The exception to this would be limited past regional inclusion in cancer research, especially community based research, conducted by institutions such as the University of Virginia or the University of Kentucky. In addition, Wellmont and Mountain States have extended some clinical trials into sites in Southwest Virginia. Wellmont and Mountain States do not currently have a comprehensive academic medical center model in place. Rather, there are teaching programs conducted in partnership with both Virginia and Tennessee medical schools at the tertiary hospitals and at Johnston Memorial Hospital, Norton Community Hospital, and Lone Pine Hospital—all in Virginia. In addition, both health systems have research programs that are primarily made up of clinical trials. The Virginia population for these trials and new ones and the expansion of opportunities for primary research, particularly translational research with Virginia academic partners, will expand under Ballad Health through the $85 million in funding made possible by the merger efficiencies. The academic medical center concept for Ballad Health will be further defined through the development of the 10-year plan for Academics and Research.

The Research and Academics Community Health Work Group is made up of representatives of our academic partners in Virginia and Tennessee and has proposed a model for collaboration and the development of cross institution working relationships to promote significantly enhanced research opportunities. (see attached) Though specific plans and expenditures have not yet been determined, this Work Group proposal will serve as a starting point for the development of a ten-year plan for academics and research, which will include a significant emphasis on Southwest Virginia. In Revised Commitment 17, the New Health System commits to furnish to the Commissioner a 10-year plan for medical residency training programs and other health care professional training no later than June 30, 2018. In Revised Commitment 18, by the end of the first fiscal year after the merger, the New Health System commits to present a plan to the Commissioner for research expenditures for full fiscal years two and three starting after the closing of the merger. See **Exhibit O-1A** for additional details about these Commitments.

The size of the population served, the number of annual admissions and visits, the rural nature of the region, the distinctly disparate health characteristics of the population, and the ability to share health data across the population all create a unique combination of opportunities for research conducted in Southwest Virginia. Yet, there is a lack of sufficient infrastructure to attract research funding or to establish self-funded research opportunities and an absence of collaborative mechanisms that can function cohesively to support regional research. Our primary aim is to enable translational research opportunities which will ultimately improve the health of the population we serve and inform the overall body of research on the health issues faced by our region—particularly

those where behaviors and socio-economic factors impact health status. In so doing, the research goals of Ballad Health will support our community health improvement goals and will further our ability to create significant public advantage through improvement in poor health trends over time.

We will work with existing academic partners and explore new relationships to better understand the underlying causes of higher rates of obesity, tobacco use, physical inactivity, and substance abuse and to test strategies to work with populations to prevent correlating diseases such as diabetes, heart disease, and cancer in Southwest Virginia. We also have the opportunity to conduct research on super-utilizers of health care, especially those within the Medicaid, Medicare, and uninsured populations to test strategies to reduce unnecessary, high-cost utilization and to improve the health of those populations.

Early in the process, our focus will be on the development of the plan and priority areas of focus, the design of the collaborative mechanisms, and the development of the regional infrastructure and talent base. Creation of this foundation will be necessary to optimize regional investments, such as those made possible by the Virginia Tobacco Commission, and to attract national funding for research projects and trials which require an existing base of resources and highly qualified scientists and other research professionals. By building on the existing resource base of multiple academic partners through focused investment, we will be able to achieve a more efficient and less duplicated approach.

V.C.9.

9. Provide specific dollar amounts expected to be provided to research programs. Specify dollar amount, research program, issues studied and the expected outcome measures?

JOINT RESPONSE: As noted in Response C7 above, Ballad Health will utilize a portion of the $85 million investment in academics and research to create new opportunities both to enroll Virginia participants into clinical trials in areas such as cardiology and cancer research and to establish new translational research opportunities in the region. The Research & Academics Work Group is made up of representatives of our academic partners in Virginia and Tennessee and has proposed a model for collaboration and the development of cross institution working relationships to promote significantly enhanced research opportunities. (See attached **Exhibit C-1F** for the Research & Academics Work Group initial report.) Though specific plans have not yet been set forth and specific expenditures have not yet been determined, this proposal will be the basis for development of a ten-year plan for academics and research, which will include a significant emphasis on Southwest Virginia working with academic institutions in Virginia.

Our primary aim is to enable translational research opportunities which will ultimately improve the health of the population we serve and inform the overall body of research on the health issues faced by our region—particularly those where behaviors and socio-economic factors impact health status. In so doing, the research goals of Ballad Health will support our community health improvement goals and will further our ability to create significant public advantage through improvement in poor health trends over time.

We will work with existing academic partners and explore new relationships to better understand the underlying causes of higher rates of obesity, tobacco use, physical inactivity, and substance abuse and to test strategies to work with populations to prevent correlating diseases such as diabetes, heart disease, and cancer. We also have the opportunity to conduct research on super-utilizers of health care, especially those within the Medicaid, Medicare, and uninsured populations to test strategies to reduce unnecessary, high-cost utilization and to improve the health of those populations.

Early in the process, our focus will be on the development of the plan and priority areas of focus, the design of the collaborative mechanisms, and the development of the regional infrastructure and talent base. Creation of this foundation will be necessary to optimize regional investments, such as those made possible by the Virginia Tobacco Commission, and to attract national funding for research projects and trials which require an existing base of resources and highly qualified scientists and other research professionals. By building on the existing resource base of multiple academic partners through focused investment, we will be able to achieve a more efficient and less duplicated approach.

Our expected outcome is a body of research which will directly benefit the people of Southwest Virginia by providing new clinical trial opportunities for the treatment of disease, new levels of understanding about the unique contributors to the poor health status of the region, and new strategies to prevent the development and progression of disease and its negative impact on people's lives.

While detailed areas of focus and expenditures will require the development of the ten-year plan with partners, following is an estimated rate of annual expenditure for the $85 million in academic and research:

	Academic and Research Reinvestment from Efficiencies Generated by the Merger
Year 1	*3,000,000*
Year 2	*5,000,000*
Year 3	*7,000,000*
Year 4	*10,000,000*
Year 5	*10,000,000*
Year 6	*10,000,000*
Year 7	*10,000,000*
Year 8	*10,000,000*
Year 9	*10,000,000*
Year 10	*10,000,000*
TOTAL	***$ 85,000,000***

V.D.1.

D. Tertiary Programs

1. **Please detail the utilization by DRG (using VHI and an equivalent Tennessee patient level data base) of Virginia patients from the Virginia geographic service area at each of the three (3) NHS tertiary hospitals in Tennessee and at other Virginia tertiary competitors including Carilion Clinic, Inova, UVA Health System, VCU Medical Center and Sentara Healthcare over the two (2) year historical baseline period.**

JOINT RESPONSE: The requested information is attached. The data was compiled using state databases in Virginia and Tennessee, as well as North Carolina, and include services with a DRG Relative Weight of at least 2.0 (as discussed in Response D-2).

INDEX OF DOCUMENTS:

- Exhibit D-1 Virginia Patient DRGs for Tertiary Hospitals

V.D.2.

2. **Please provide a DRG based definition of the tertiary services that each Applicant facility provides. This definition should be based on an assessment of DRGs that are uniquely or predominantly provided at an applicant's academic medical center and other Virginia academic medical centers.**

JOINT RESPONSE: Tertiary services were defined using a Relative Weight (RW) of 2.0 or higher by DRG. CMS assigns RWs to specific DRGs based upon the amount of resources that must be consumed to care for a patient in a given DRG group. By considering DRGs with RWs of 2.0 or higher, we eliminate about 50% of lower acuity DRGs and provide a more accurate representation of "tertiary services." Further, a defined RW allows for consistent measurement and comparison against all other hospitals and academic medical centers. See C.4 below for more information on the tertiary services provided at NHS academic medical centers.

NHS will continue to support multiple teaching hospitals providing graduate medical education and expand access to offerings of an academic medical center – a university-based or completely intertwined university relationship – as part of the Academics and Research plan.

V.D.3.

3. **Please calculate the market share of tertiary service in the Virginia geographic market defined in the Application that is held by each NHS tertiary provider and each Virginia competitor.**

   JOINT RESPONSE: The requested information is provided. The data include services with a DRG Relative Weight of at least 2.0 (as discussed in Response D-2). .

   INDEX OF DOCUMENTS:

   - Exhibit D-3 Market Share Tertiary Service in Virginia Counties

V.D.6.

6. **Why are there no plans for locating tertiary care services in a Virginia hospital or other facility within the merged system?**

JOINT RESPONSE: While certain tertiary services may be offered in Southwest Virginia where volume levels and physician resources can support them with high quality, there are no plans to locate a major tertiary facility in Southwest Virginia.

Tertiary hospitals are noted for high volume and the availability of highly specialized services, which require enough volume to support the ongoing skill development of staff. In a tertiary hospital, there must be sufficient physicians in each specialty and highly-trained and specialized staff to support them. In order to attract and justify these specialized physician and staff resources for a tertiary hospital, there must be sufficient critical mass of patient population to support the investment.

Because Southwest Virginia is geographically large, topographically divided and sparsely populated, the region does not have the ability to support such a tertiary hospital on its own. Travel patterns also vary from the Highway 23/Interstate 26 corridor and the Interstate 81 corridor, making effective placement of one tertiary center difficult and inconsistent with the goal of improving patient access. Having said that, Holston Valley Medical Center and Bristol Regional Medical Center are located very near the state line and strategically located along the two main traffic corridors mentioned above. Residents of Southwest Virginia are very accustomed to using these facilities for tertiary services, as shown in the data included in **Exhibit D-1** and **Exhibit D-4.**

Finally, hospital use rates are declining in Southwest Virginia and nationally, and the need for more hospitals is in question. The objective of the NHS will be to keep needed services in close proximity to where people live, to the extent it is practical and appropriate. For these reasons, the Applicants do not foresee the further development of a tertiary hospital in Southwest Virginia.

V.G.7.

7. **The mix of the board of directors and of senior management for the new system appears to parcel out duties equally between Mountain States Health Alliance and Wellmont Health System. How will the mix of the board of directors and senior management at NHS provide for a greater representation of Virginia facilities? Provide specific details.**

JOINT RESPONSE: The Parties believe that the governance of the New Health System should reflect the region, including both Virginia and Tennessee. Response to Question G-1 above provides specific details of meaningful Virginia representation on the NHS board and board committees. In consultation with the Authority, the Parties have made revised commitments to ensure greater Virginia presence in NHS leadership.

Senior corporate management of the NHS will be based in Tennessee, where the majority of NHS operations exist. It is therefore likely that most senior corporate management will reside in Tennessee. The Parties anticipate that NHS will continue to have regional markets post-merger, but the organization of these markets is not yet determined. The Parties anticipate that the functions of the market CEOs will remain the same – to provide locally-focused management of clinical care and operations in the geographic areas they represent.

MSHA currently operates with a structure of regional markets, with a chief executive officer of each market. **Table G-7** below shows MSHA's current regional markets.

Table G-7 – MSHA Current Regional Markets

MSHA's regional markets are organized based on referral patterns. As **Table G-7** demonstrates, 1 market is fully Virginia-based, 1 market is comprised of both Tennessee and Virginia areas, and 2 markets are wholly Tennessee-based. The MSHA regional market CEOs are given broad authority to manage strategy and operations within their markets and do so based on local needs and considerations. The regional market CEOs have significant input on MSHA corporate strategy and direction.

Wellmont currently utilizes a similar market leadership structure as the one described for Mountain States. This includes regional hospital market CEOs which report to the chief operating officer of the health system for the following markets: Bristol, Kingsport, Wise County, Hawkins and Hancock Counties, and Greene County. Similar to Mountain States, these markets are based on the location of hospital facilities and the referral patterns associated with them.

V.J.1.

J. Health Insurance Relationships

1. **Please describe all existing health insurance relationships by company and by Virginia facility.**

   a. **This should include plans offered to employees and plans entered into by each health care facility, hospital or service to provide care.**

   b. **Please provide copies of all such contracts currently in force.**

MSHA RESPONSE: MSHA has no health insurance products that it offers to patients or employees. All applicable requested information is provided.

MSHA believes that **Exhibit J-1A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit J-1A MSHA Virginia Health Insurance Relationships – **PROPRIETARY**

WHS RESPONSE: WHS is part of a regional physician-hospital partnership with Highlands Physicians, Inc. that provides high-quality, cost effective continuum of health care services to area employer groups. WHS does not independently own any health insurance products that it offers to patients or employees. All applicable requested information is provided.

WHS believes that **Exhibit J-1B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit J-1B WHS Virginia Health Insurance Relationships – **PROPRIETARY**

V.K.2.

2. **The Application commits to three tertiary hospitals (Bristol Regional, Johnson City Memorial, and Holston Valley Medical Center) – all located in the state of Tennessee. Mountain States Health Alliance opened Johnston Memorial Hospital in Abingdon, Virginia. Johnston Memorial provides significant obstetrics and acute care services to Medicaid members in the region. Describe the current and planned array of secondary, as well as tertiary services, offered at Johnston Memorial to meet the needs of Southwest Virginia Medicaid members who, in many cases, are required to travel significant distances over difficult roads and terrain, frequently in inclement weather, to access services at Johnston Memorial. In your description, please highlight services which are not available.**

   JOINT RESPONSE: Mountain States Health Alliance worked with the Johnston Memorial Hospital Board and Foundation to construct and open a new replacement hospital off exit 19 in Abingdon, Virginia. Since the new hospital opened in 2011, Johnston Memorial Hospital (JMH) has added services in the areas of interventional cardiology, vascular surgery, a primary care residency program, critical care/intensivists, infectious disease, endocrinology, and orthopedic hospitalists. Currently, the only additional services being explored for JMH are Level II neonatal nursery capabilities. There are no tertiary level services being planned for JMH, due largely to lack of a sufficient population base and the proximity of Bristol Regional Medical Center (about 20 minutes' drive away). Ballad Health anticipates retaining a significant array of obstetrics and acute care services at Johnston Memorial Hospital to serve its current and future patient base, including Medicaid patients.

   The tertiary level services that are not available at JMH are a Level III neonatal nursery, cardiovascular surgery, neurosurgery, Level I trauma, pediatric specialty and sub-specialty care, and neuro-endovascular services. All of these services are available at Bristol Regional Medical Center, Holston Valley Medical Center, or Johnson City Medical Center.

V.K.4.

4. **The Application, page 42, states that "The New Health System will work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region." Please provide more information as to what academic institutions will be included. Does this include academic medical centers in Virginia that have established referral patterns in Southwest Virginia, such as the Virginia Tech Carillion School of Medicine and Research Institute in Roanoke and the University of Virginia in Charlottesville?**

JOINT RESPONSE: Ballad Health will work with all existing academic partners to establish the overall 10-year plan for Academics and Research—with appropriate institutions involved in either the academics or research components of the plan. This includes the following academic partners in Virginia and Tennessee with whom we work closely to educate medical professionals or to collaborate on research initiatives:

- University of Virginia
- East Tennessee State University, Quillen College of Medicine
- Lincoln Memorial University, Debusk College of Osteopathic Medicine
- Edward Via College of Osteopathic Medicine
- Emory & Henry College
- Milligan College
- King University
- Tusculum College
- Northeast State Technical Community College
- Virginia Highlands Community College
- Southwest Virginia Community College
- Mountain Empire Community College

In the future, we will also explore options for collaboration with other Virginia institutions, especially those with ties to the region and those noted for research capability such as Virginia Tech and Virginia Commonwealth University.

V.K.6.

6. **Mental health, behavioral health, addiction, and substance abuse services are an important component of Medicaid, especially in the region the New Health System will serve. Please describe in greater detail the commitments the New Health System will make to address these needs. Include type of service, location of the treatment providers and facilities, number of beds available, and how decisions will be made as to whether to increase/reduce beds or treatment at a facility or in the community.**

JOINT RESPONSE: The NHS will commit to incremental spending of at least $85 million over ten years on behavioral health services, including new capacity for residential addiction recovery services and community-based behavioral health resources, such as mobile health crisis management teams and intensive outpatient treatment for adults, children, and adolescents. Due to antitrust constraints, the Parties are not yet able to develop budgets and implementation plans for the NHS's model of care for behavioral health.

Given the extent of the need for these services in the region, it is expected that even with the NHS new commitment to behavioral health, not all needs will be met in Southwest Virginia. Ultimately, it is important that the NHS investment is leveraged with other capability and sources of funds in the region. For this reason, the care model implemented will be coordinated, co-located, and integrated with Virginia Community Service Board services, hospitals, FQHCs, RHCs and local primary care providers, faith based organizations and health departments and to overcome the disparate and disconnected manner in which patients are currently treated. The NHS will work with collaborative organizations such as OneCare to accomplish this coordination.

Substance Abuse Disorder

With respect to substance abuse disorder, the extent of the addiction crisis is well documented in the applicant's service area.[18] 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 third largest topic of concern in the community.[19] 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.[20] Last November, Commissioner Levine declared the Virginia opioid addiction crisis a Public Health Emergency. - In remarks addressing her declaration, she noted:

[18] *See* Application Section 15.a.A, pages 68-95.
[19] The Community Health Roundtable meetings identified community development and access to services as the top two topics of concern.
[20] *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 .

> [T]he facts clearly tell us that the consequences of opioid addiction in Virginia have risen to unprecedented levels and can now be classified as epidemic [including] ***the continuing prescription opioid crisis most prominent in the far southwest region of the Commonwealth where we are additionally concerned about the growing prevalence of hepatitis C and HIV resulting from injection drug use.***[21]

As a result, substance abuse prevention and treatment services are identified as top priorities in the Applicants' suggested investments in public health initiatives and improved specialty services access.

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."[22]

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.[23] The American Society of Addiction Medicine ("ASAM") identifies five broad levels of 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.[24]

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.[25,26] When individuals are placed on waiting lists, 25-50 percent never enter treatment. [27]

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[21] Comments available at http://www.vdh.virginia.gov/blog/2016/12/27/state-health-commissioner-comments-on-opioid-addiction-declaration/.

[22] 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.

[23] NAT. INST. ON DRUG ABUSE, *DrugFacts* 2 (July 2016), *available at* https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction.

[24] *Id.*

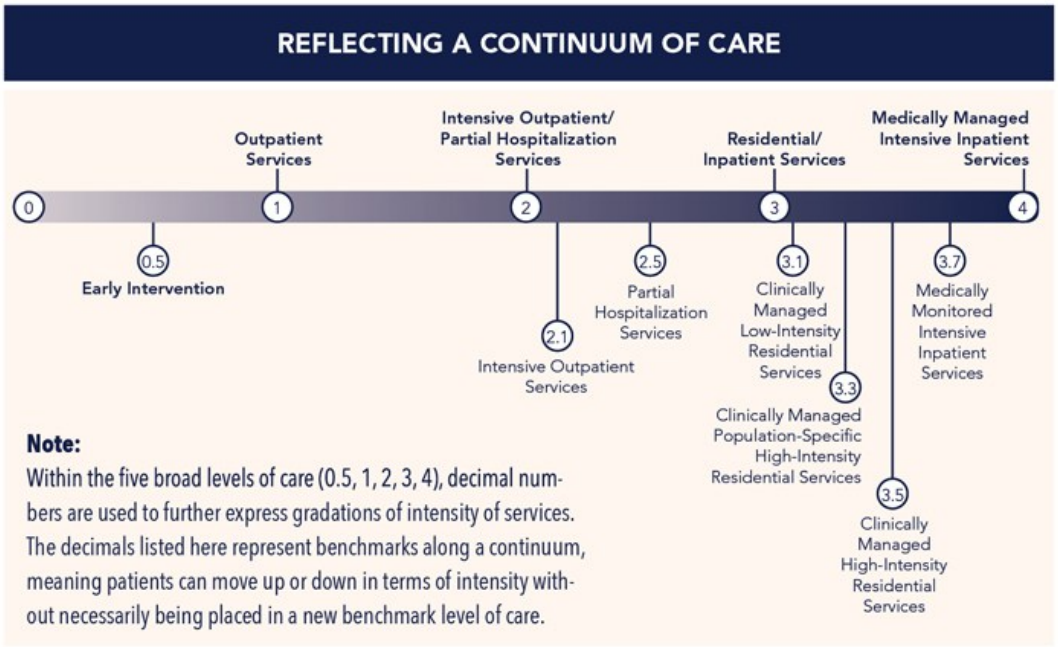
[25] *Id.*

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.[28]

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.*"

Figure 1: ASAM Continuum of Service Intensity



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.[29] The focus is recovery which "is seen as a gradual, ongoing

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[26] NAT. INST. ON DRUG ABUSE: RESEARCH REPORT SERIES, *Therapeutic Community* (2012), *available at* https://archives.drugabuse.gov/pdf/RRTherapeutic.pdf.
[27] 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/.
[28] *Therapeutic Community*, *supra* n10.
[29] *Therapeutic Community*, *supra* n10 at 4.

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."[30] Interventions include clinical groups, community meetings, and vocational, educational, community, and clinical activities.[31] 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.

Serious Mental Illness

As of now, the behavioral health service offerings in the applicants' Virginia hospitals are limited to treatment of patients within the Emergency Departments and within three dedicated inpatient units: 10 geropsych beds at Dickenson Community Hospital in Clintwood, 20 adult psychiatric beds at Russell County Medical Center in Lebanon, and 28 adult psychiatric beds at Wellmont Ridgeview in Bristol, Virginia. Historically both health systems have been focused primarily on inpatient psychiatric services with minimal outpatient services. Generally, behavioral health care in the region is not well coordinated or integrated across primary care, outpatient care and inpatient care much less across schools, social services, and law enforcement, resulting in increased costs through the overutilization of inpatient services and decreased effectiveness of care.

There is little disagreement that the inpatient-focused model increases costs, creates significant gaps in care and is inadequate to meet the growing mental health needs of the population. Inpatient care alone is not sufficient to create an effective system of care to address the behavioral health needs of the community. For this reason, the NHS proposes to make new incremental investments in integrated primary care and behavioral health,[32] intensive outpatient treatment and mental health crisis response teams.

One model of integrated primary care and behavioral health that the NHS may expand on is the behavioral health care navigator (BHCN) currently being piloted between Mountain States Medical Group and Frontier Health. The BHCN is a part of the care management team working directly with the Mountain States' 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.

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[30] 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.

[31] *Therapeutic Community*, *supra* n10 at 5.

[32] According to one 2013 study, 32% of study patients with psychosis had no behavioral health care before their initial diagnosis, and almost 50% were first diagnosed in the emergency department. *Patterns of health services use prior to a first diagnosis of psychosis: the importance of primary care,* Anderson KK, Fuhrer R, Wynant W, Abrahamowicz M, Buckeridge DL, Malla, Soc Psychiatry Psychiatr Epidemiol. *2013 Sep;48(9):1389-98. doi: 10.1007/s00127-013-0665-3. Epub 2013 Feb 21..* Available at http://www.ncbi.nlm.nih.gov/pubmed/23429939.

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.

One form of Intensive Outpatient Services which reduce the need for hospitalization and stabilize housing and employment for persons diagnosed with a serious mental illness is Assertive Community Treatment, or ACT. ACT is a way of delivering a full range of services that give these

individuals adequate community care and to help them have a life that isn't dominated by their mental illnesses. ACT services are characterized by:[33]

- A team approach: Psychiatrists, nurses, mental health professionals, employment specialists, and substance-abuse specialists join together on ACT teams to give consumers ongoing, individualized care.
- Services provided when where they are needed: Consumers receive ACT services in their homes, where they work, and in other settings in the community when and where problems occur or support is needed 24/7.
- Personalized and continuous care: ACT teams work with relatively small numbers of people and several ACT team members work regularly with each consumer.
- Comprehensive and time-unlimited support: Rather than relying on referrals, ACT teams provide an array of services to help meet consumer needs and give consumers whatever services and supports they need for as long as they need them.

Individuals with serious mental illness often experience a cascade of crisis events that place them at high risk for negative outcomes such as homelessness, arrest and incarceration, employment termination, hospitalization and readmission, and loss of parental rights.[34] Often, these events are the result of an initial acute interaction with an authority not trained in mental health and crisis de-escalation where an actual or perceived threat of harm exists. With limited options at their disposal, these authorities default to the options available to them and for which they were trained: police to arrest, landlords to eviction, schools to expulsion and so on.

Emergency Stabilization/Crisis Management programs can provide an array of services designed to appropriately deescalate mental health crisis. They include 24/7 call centers, drop off crisis stabilization units, mobile response teams. The Substance Abuse and Mental Health Administration has defined a number of principles for implementing crisis response which include:[35]

- services that are trauma informed, timely, and provided in the least restrictive manner;
- care plans that are strength based, prevention focused, and congruent with an individual's culture, gender, race, sexual orientation, age, and communication capability;
- provided by individuals with appropriate training and demonstrated competencies to comprehensively evaluate and effectively intervene in crisis.

<u>Collaboration with Community Partners</u>

Decision regarding the location of each of these services will be made in close collaboration with community based mental health partners such as the CSBs and OneCare collaborative in Virginia. Facility based services may be new construction, or leverage existing assets owned by the NHS or

[33] http://store.samhsa.gov/shin/content//SMA08-4345/BuildingYourProgram-ACT.pdf accessed on January 5, 2017
[34] http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf accessed on January 5, 2017.
[35] https://www.macmhb.org/sites/default/files/attachments/files/Workshop%209%20Community%20Crisis%20Center%20MACMHB%20Presentation%20thumb.pdf accessed on January 6, 2017.

community partners. Community based services may be newly organized, or may leverage existing services run by community partners. Because of anti-trust concerns, the parties are not yet able to enter into the detailed planning required to identify where these services will be located and what existing assets and resources of the parties may be mobilized. Ultimately the decision will be data driven and match needs again capacity to determine the best deployment model.

V.M.3.

3. **Provide an electronic copy (with documentation) of the NHS Baseline Financial Model. List the contact information of all individuals who developed this model.**

JOINT RESPONSE: The requested information is provided

The Parties believe that **Exhibit M-3C** is proprietary, confidential and competitively sensitive under federal antitrust laws. The Parties will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-3A Joint Contact Information for FTI Consulting, Inc.
- Exhibit M-3B Joint NewCo Baseline Financial Model Information – PUBLIC
- Exhibit M-3C Joint NewCo Baseline Financial Model Information and Report of FTI Consulting, Inc. – **PRORPRIETARY**

V.M.4.

4. **Provide an electronic copy (with documentation) of the NHS Baseline Financial Model showing each schedule previously presented for the aggregate of the Virginia facilities. Provide PDF and Excel versions of the schedules.**

   JOINT RESPONSE: The NHS Baseline Financial Model was prepared with the entire system in mind. Due to federal antitrust concerns, specific decisions have not been made about individual facilities. As a result, information for the aggregate of the Virginia facilities cannot be presented separately at this time.

V.M.6.

6. **Please provide the contact information for the individuals responsible for the third party payer negotiations at MSHA and WHS.**

MSHA RESPONSE: Third-party payer negotiations for MSHA are conducted by Marvin Eichorn and Paula Claytore.

Marvin Eichorn
Executive Vice-President, Chief Operating Officer
Phone: (423) 302.3372
Email: EichornMH@msha.com

Paula Claytore
Vice-President, Managed Care
Phone: (423) 431.6147
Email: ClaytorePM@msha.com

WHS RESPONSE: Third-party payer negotiations for WHS are conducted by Todd Dougan and Stephanie Metcalf.

Todd Dougan
Chief Financial Officer
Phone: (423) 230-8512
Email: Todd.Dougan@wellmont.org

Stephanie Metcalf
Wellmont and PHO Facility Contract Manager
Phone: (423) 844-4188
Email: Stephanie.Metcalf@wellmont.org

V.M.7.

7. **Please provide a copy of the charge master utilized by MSHA and WHS in the two (2) year historical baseline period (Excel or Access formats only). Show item charges, item total revenue, and item total net revenue for MSHA and WHS facilities for each year.**

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibit M-7A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-7A MSHA FY13-14 and FY14-15 Charge Masters– **PROPRIETARY**

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibit M-7B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's

INDEX OF DOCUMENTS:

- Exhibit M-7B WHS Charge Master Utilized by WHS in the Two Year Historical Period – **PROPRIETARY**

V.M.8.

8. Please provide the charge master currently in force for MSHA and WHS (in Excel or Access).

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibit M-8A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-8A MSHA Current Charge Master– **PROPRIETARY**

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibit M-8B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-8B WHS Charge Master Currently in Force– **PROPRIETARY**

V.M.13.

13. Please describe the strategy by which NHS will implement a charge master policy.

a. Will there be a unified charge master?

JOINT RESPONSE: Yes**.** NHS will have a unified charge master for all services within a reasonable time period after the merger closing.

b. How will Virginia facilities be treated?

JOINT RESPONSE: The NHS unified charge master will cover all facilities and services in Virginia and Tennessee. The pricing for services in Virginia, as detailed in the charge master, will be the same as in Tennessee.

c. How will the charge master be different for tertiary teaching facilities and rural facilities?

JOINT RESPONSE: The NHS charge master will have the same price for each code, no matter where the service is performed. The three tertiary teaching facilities will perform certain services that the other facilities will not perform, and as such, will be the only facilities to utilize certain codes.

d. Will charge master prices be different for the same items in hospitals, outpatient facilities, physician services, or other settings?

JOINT RESPONSE: Within no later than one year after closing, NHS will have a common charge master for all of its hospitals, physician practices, nursing homes, and ambulatory and ancillary services. The NHS common charge master will result in the same charges for the same services or codes across all of the NHS's facilities and offices. In the interim, the rationale for applying charges to various settings of care will be consistent with the methodology currently used by Wellmont and Mountain States and will also be consistent with the state and federal rules applying to hospital-based and provider-based services as designated by appropriate state and federal agencies.

e. In the budgeting process, during which month are charge master prices typically updated?

JOINT RESPONSE: The charge master prices are typically updated on the first day of each fiscal year, which would be July 1st.

V.M.14.

14. **Please provide detailed utilization and revenue statistics for hospital, outpatient and physician services for each Virginia facility for Medicaid Managed Care, Tricare, Medicare Advantage and any other governmental plans for the two (2) year historical baseline period, YTD and the five (5) year forecast period.**

JOINT RESPONSE: In order to provide the requested information for the New Health System for the five (5) year forecast period, the Parties would be required to share competitively sensitive information that is not normally shared between competitors due to antitrust concerns. To date, the Parties have not shared this highly sensitive information with each other because of these concerns. Each Party risks violating federal antitrust laws if it shares this information with the other Party, other competitors or other insurers as a public document. For these reasons, we have been unable to develop detailed utilization and revenue projections. However, utilization and revenue assumptions are included in the FTI financial model provided in **Exhibits M-3B and M-3C**.

MSHA RESPONSE: MSHA does not forecast this information, but all other historical and YTD requested information is provided.

MSHA believes that **Exhibit M-14A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-14A MSHA Utilization and Revenue Stats for Virginia Facilities – **PROPRIETARY**

WHS RESPONSE: WHS does not forecast this information, but all other historical and YTD requested information is provided.

WHS believes that **Exhibits M-14B and 14C** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-14B WHS Hospital Utilization and Revenue Statistics - **PROPRIETARY**
- Exhibit M-14C WHS Physician Utilization and Revenue Statistics – **PROPRIETARY**

V.M.15.

15. **Please provide detailed utilization and revenue statistics for hospital, outpatient, and physician services for each tertiary hospital for Virginia Medicaid programs, Tennessee Medicaid programs, Tricare, Medicare Advantage, and any other government plans for the two (2) year historical baseline period, YTD, and the five (5) year forecast period.**

JOINT RESPONSE: In order to provide the requested information for the New Health System for the five (5) year forecast period, the Parties would be required to share competitively sensitive information that is not normally shared between competitors due to antitrust concerns. To date, the Parties have not shared this highly sensitive information with each other because of these concerns. Each Party risks violating federal antitrust laws if it shares this information with the other Party, other competitors or other insurers as a public document. For these reasons, we have been unable to develop detailed utilization and revenue projections. However, utilization and revenue assumptions, along with payer mix assumptions, are included in the FTI financial model provided in **Exhibits M-3B and M-3C**.

MSHA RESPONSE: MSHA does not forecast this information, but all other historical and YTD requested information is provided.

MSHA believes that **Exhibit M-15A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-15A MSHA Utilization and Revenue Stats for Tertiary Hospital – **PROPRIETARY**

WHS RESPONSE: WHS does not forecast this information, but all other historical and YTD requested information is provided.

WHS believes that **Exhibits M-15B and 15C** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-15B WHS Hospital Utilization and Revenue Statistics – **PROPRIETARY**
- Exhibit M-15C WHS Physician Utilization and Revenue Statistics – **PROPRIETARY**

V.M.16.

16. **Please provide detailed utilization and revenue statistics for hospital, outpatient and physician services for uninsured patients at each Virginia facility for the two (2) year historical baseline period, YTD and the five (5) year forecast period. Provide similar aggregate statistics for the Virginia facilities.**

JOINT RESPONSE: In order to provide the requested information for the New Health System for the five (5) year forecast period, the Parties would be required to share competitively sensitive information that is not normally shared between competitors due to antitrust concerns. To date, the Parties have not shared this highly sensitive information with each other because of these concerns. Each Party risks violating federal antitrust laws if it shares this information with the other Party, other competitors or other insurers as a public document. For these reasons, we have been unable to develop detailed utilization and revenue projections. However, utilization and revenue assumptions, along with payer mix assumptions, are included in the FTI financial model provided in **Exhibits M-3B and M-3C**.

MSHA RESPONSE: MSHA does not forecast this information, but all other historical and YTD requested information is provided

MSHA believes that **Exhibit M-16A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-16A MSHA Utilization and Revenue Stats for Uninsured Patients-Virginia – **PROPRIETARY**

WHS RESPONSE: WHS does not forecast this information, but all other historical and YTD requested information is provided.

WHS believes that **Exhibits M-16B, 16C and 16D** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-16B WHS Hospital Utilization and Revenue Statistics – Charity Care – **PROPRIETARY**
- Exhibit M-16C WHS Hospital Utilization and Revenue Statistics – Charity Care and Uninsured – **PROPRIETARY**

- Exhibit M-16D WHS Hospital Utilization and Revenue Statistics – Uninsured – **PROPRIETARY**

V.M.17.

17. **Please provide detailed utilization and revenue statistics for hospital, outpatient and physician services for charity care patients at each Virginia facility for the two (2) year historical baseline period, YTD and the five (5) year forecast period. Provide similar aggregate statistics for the Virginia facilities.**

JOINT RESPONSE: In order to provide the requested information for the New Health System for the five (5) year forecast period, the Parties would be required to share competitively sensitive information that is not normally shared between competitors due to antitrust concerns. To date, the Parties have not shared this highly sensitive information with each other because of these concerns. Each Party risks violating federal antitrust laws if it shares this information with the other Party, other competitors or other insurers as a public document. For these reasons, we have been unable to develop detailed utilization and revenue projections. However, utilization and revenue assumptions, along with payer mix assumptions, are included in the FTI financial model provided in **Exhibits M-3B and M-3C**.

MSHA RESPONSE: MSHA does not forecast this information, but all other historical and YTD requested information is provided.

MSHA believes that **Exhibit M-17A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-17A MSHA Utilization and Revenue Stats for Charity Care Patients_Virginia – **PROPRIETARY**

WHS RESPONSE: WHS does not forecast this information, but all other historical and YTD requested information is provided.

WHS believes that **Exhibits M-17B, 17C and 17D** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit M-17B WHS Hospital Utilization and Revenue Statistics – Charity Care – **PROPRIETARY**
- Exhibit M-17C WHS Hospital Utilization and Revenue Statistics – Charity Care and Uninsured – **PROPRIETARY**

- Exhibit M-17D WHS Hospital Utilization and Revenue Statistics – Uninsured – **PROPRIETARY**

V.M.20.

20. What are the proposed policies to reduce or restrain pricing for all third party payers including those that have less than 2% of volume?

JOINT RESPONSE: Ballad Health proposes the following policies and commitments to reduce or restrain pricing for all third-party payers, all of which are revised from original commitments made in the Application and made in consultation with the Authority: [37]

1. **Commitment:** In order to minimize any adverse impact on the ability of insurance companies to contract with the hospitals, and while this Cooperative Agreement ensures open access and choice for all consumers to choose any hospital in the region, it also remains the intent of the Cooperative Agreement that consumers and businesses enjoy a competitive market for insurance. As such, the New Health System will negotiate in good faith with Principal Payers to include the New Health System in health plans offered in the Geographic Service Area on commercially reasonable terms and rates (subject to the limitations herein). The New Health System will not unreasonably refuse to negotiate with potential new entrants to the market or with insurers that do not meet the definition of "Principal Payer", as long as the payer has demonstrable experience, a reputation for fair-dealing and timely payment, and negotiates in good faith. New Health System will resolve through mediation any disputes as to whether this commitment applies to the proposed terms of a health plan contract. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this commitment if the payer has insureds (or members) in the Commonwealth of Virginia, and shall offer to the Commissioner updates on the progress of such mediation.

   Timing: Immediately upon closing of the merger and then upon expiration of existing contracts or with contracts with any new payers coming into area, and ongoing.

   Amount: No cost.

   Metric: Complaints from payers and credible report by the New Health System.

2. **Commitment:** In order to ensure pricing is not increased as a result of the elimination of inpatient competition for the majority of consumers covered by third party commercial insurance, pricing will increase by less with the merger than if the merger were not to occur. For all Principal Payers[38], the New Health System will reduce existing commercial contracting for

[37] See **Exhibit G-1A** for a complete list of current commitments made by Ballad Health as part of its proposal for the Cooperative Agreement.

[38] For purposes of the Application and proposal in the Cooperative Agreement, "Principal Payers" are defined as those commercial payers and governmental payers with negotiated rates who provide more than two percent (2%) of the New Health System's total net revenue. (All of a payer's revenue shall be considered in calculating the revenue percentage even if the payer has more than one contract with the New Health System.) The proposed commitments would not apply to traditional Medicare or any other payers that provide two percent (2%) or less of the New Health System's net revenue. Notwithstanding any provision to the contrary, the limitation on rate

fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement. Applicants represent that the fiscal year for the New Health System will end on June 30, and that the fiscal year will not change until after the second full year commencing after the closing date of the New Health System

Timing: Second full fiscal year commencing after the closing date of the New Health System.

Amount: The estimated annual savings to consumers for the combination of Commitments 1 and 2 are $10 million in lower health care costs annually.[39]

3. **Commitment:** To ensure the Cooperative Agreement protects consumers from pricing increases that could otherwise result from the elimination of competition, a limit on pricing growth is applied for each year to restrain pricing growth to below the national hospital consumer price index. Effective on the closing date of the merger, the New Health System will commit to not adjust hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This is a ceiling in rate adjustments; nothing herein establishes these adjustments as the floor on rates. To the extent, if any, that the Applicants negotiate contracts with Principal Payers between October 10, 2016 and the closing date of the merger and such contracts include fixed rate increases in excess of the hospital Consumer Price Index for hospital inpatient and outpatient services and the medical care Consumer Price Index for physician and non-hospital outpatient services compared with previous contracts with the same payer, no later than one month following the closing date, New Health System will rollback its rates to what they would have been if the negotiated rates of increase had been no more than the above-referenced Consumer Price Index changes. Applicants represent that their current contracts with Anthem for nongovernmental patients will not expire prior to the now-expected date of the rate increase commitment becoming effective, i.e., July 1, 2018.

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increases applicable to insurers providing coverage on behalf of governmental payers (i.e., Medicare Advantage Plans or Medicaid Plans) does not apply if the adjustments are tied to actions made by government entities, including but not limited to, market basket adjustments, adjustments tied to area wage index, or other governmentally imposed rate adjustments. The limitations on pricing committed to by the parties are intended to ensure price increases beyond the limits imposed by the Cooperative Agreement (COPA) do not occur as a result of increased market concentration resulting from the merger transaction. The price limits imposed by the Cooperative Agreement (COPA) are not intended to interfere with government-imposed pricing which would occur with or without the creation of the New Health System. To the degree pricing for insurers providing coverage on behalf of governmental payers is tied contractually to Medicare rates (i.e., a percent of Medicare), the Cooperative Agreement (COPA) is not intended to interfere with such pricing relationships. The intent is to ensure future pricing is not increased as a result of the merger transaction.

[39] This estimate is nonbinding. To the extent, however, that there is a dispute on the New Health System's compliance with these rate of increase commitments, the estimate may be used as a tool to interpret what the commitment means.

This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. The New Health System agrees that contract structures may include rates being tied to a percentage of Medicare, or may establish base rates with annual inflators or quality incentives. The New Health System will not refuse to enter into any of these types of structures on the basis of the structure and will negotiate the rate structure in good faith. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval, the New Health System and a Principal Payer are unable to reach agreement on a negotiated rate, New Health System agrees to mediation as a process to resolve any disputes. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this commitment if the payer has insureds (or members) in the Commonwealth of Virginia, and shall offer updates to the Commissioner on the progress of such mediation.

Timing: Subsequent contract years.

Amount: The estimated annual savings to consumers for the combination of Commitments 1 and 2 are $10 million in lower health care costs annually.

Metric: Easily verifiable.

4. **Commitment:** In order to ensure providers in the region not affiliated with the New Health System may continue to operate competitively, and to ensure new provider entrants to the market are not disadvantaged by the New Health System, the New Health System will not require as a condition of entering into a contract that it shall be the exclusive network provider to any health plan, including any commercial, Medicare Advantage or managed Medicaid insurer. Nothing herein shall be construed as to impede the discretion of the payers in the market from designating the New Health System (or components thereof), as an exclusive network provider in all or part of the New Health System's service area.

   Timing: Immediately upon closing of the merger and then upon expiration of existing contracts or with contracts with any new payers coming into area, and ongoing.

   Amount: No cost.

   Metric: Easily verifiable.

5. **Commitment:** In order to enhance quality, improve cost-efficiency and reduce unnecessary utilization of hospital services, for all Principal Payers, the New Health System will endeavor to

include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.

Timing: Immediately upon closing of the merger and ongoing.

Amount: No incremental cost.

Metric: Annual report and complaints, if any, from payers.

All of the above commitments pertain to payers that have more than 2% of the New Health System's revenues, all Medicare Advantage payers, all Medicaid managed care payers, and TriCare. These commitments do not pertain to any payer that does not meet the above criteria.

Collectively, the 95 payers that individually comprise less than 2% of the New Health System's revenues comprise less than 3% of the New Health System's total net revenues. The New Health System cannot extend the pricing commitments to the non-Principal Payers for the following reasons:

1. The vast majority of the payers in this category do not have a contract with NHS. These are payers that are based in other states or other countries that have no reason to contract with NHS due to their very small amount of annual volume.
2. The administrative burden on NHS and the payer to administer the payer commitments would be excessive relative to the amount of business that the payer has with NHS.
3. Other controls and processes are in place that will provide assurances that any annual pricing adjustments will be fair and consistent with current and past practices. These include:

   (a) requirement that gross charge increases be applied consistently across all payers;

   (b) oversight by NHS board and finance committee of changes to NHS's charge structure; and

   (c) the ability of any payer to express its concerns about any NHS pricing change to the Commissioner.

The NHS will have no incentive to charge unfair rates to two hundred payers – particularly when they together account for less than 3% of NHS's net revenue – on the hope that not one of them reports this conduct to the state in its active supervision role. We believe only one meritorious complaint would provide grounds for the Commissioner to question NHS's contracting practices.

V.O.3.

3. **If certain facilities are eliminated or their services are somehow truncated after five years, would the merged system be willing to consider, at that time, making a commitment that the remaining hospitals and services be maintained for a period of years?**

   JOINT RESPONSE: The NHS will work with the appropriate regulatory agencies to derive an effective plan to address any future consideration for the elimination of facilities. However, we believe that beyond the specific commitments set forth in the Cooperative Agreement service alignment, addition, or elimination must be the operational prerogative of the NHS as those decisions must be made with frequency and are often based on physician availability at particular times and locations. The status quo is that no guarantee exists today, and no guarantee would exist if the Parties were to merge separately with outside entities. We do believe it is important to not think in terms of preserving "facilities" and "hospitals," but instead to preserve and expand access to care. Though our current financial incentives are still oriented to treating disease in hospitals, we firmly believe that this model is evolving quickly and that the NHS can demonstrate national leadership in population health management – a model that is equally as focused on keeping people well as on treating them when ill.

   a. **If so, please provide a detailed description of a commitment proposed by the NHS.**

      JOINT RESPONSE: After five years, the New Health System will continue to provide health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. In the event that the New Health System repurposes any hospital, it will continue to provide in the community at a minimum the essential services listed in Revised Commitment 20 (see **Exhibit G-1A**) above.

V.O.13.

13. Please describe all clinical efficiencies at each Virginia facility expected to result from the merger. Detail when each will be implemented.

JOINT RESPONSE: All efficiencies currently estimated are based on the experience of the Applicants and their advisors for what is reasonable based on the historical financial operations of the Applicants and experience with similar mergers. General levels of clinical efficiency to be derived beyond those specifically set forth in the report of FTI Consulting, Inc. have not been identified or allocated by region. The Baseline Financial Model and related materials, including the report of FTI Consulting, Inc., are included in **Exhibits M-3B and M-3C**, previously referenced. As set forth in the Application,[51] the Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually. FTI Consulting and the Parties characterize the Clinical Efficiencies described in the Baseline Financial Model as "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities.

[51] Application Section 13.a, page 47.

V.O.20.

20. Are there any plans for directly providing access to needed health care services for residents of Lee County in the wake of the closure of Lee Regional Medical Center on October 1, 2013?

JOINT RESPONSE: Please see the Response to Question T-30 below.

V.Q.1.

Q. Regional Exchange Of Health Information and Information Systems

1. **Please provide any hospital long term information plans (including any consultants' reports) that have been developed at MSHA and WHS since 2009.**

MSHA RESPONSE: The requested information is provided**.**

MSHA believes that **Exhibit Q-1A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit Q-1A MSHA HIS Report – **PROPRIETARY**

WHS RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit Q-1B WHS Consultants' Reports **- PROPRIETARY**

V.Q.2.

2. **Provide documents relating to both merging parties' plans for electronic health records systems, including documents showing the current systems each is using now, plans to convert to a single records system, including its identity (including a timeline), expected benefits of the system versus using the health information exchange (HIE), and any consultant reports.**

JOINT RESPONSE: The transformation to an integrated delivery system will require a significant investment in information technology ("IT") systems. **Exhibit Q-2C** describes 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.

In addition, a high-level timeline for implementation of the Common Clinical IT Platform is attached as **Exhibit Q-2A**.[58] **Exhibit Q-2B**[59] contains information previously provided to the Authority about both Parties' plans for the Common Clinical IT Platform, including information about the current system each Party is using, plans to convert to the single system, the expected features and benefits of the Common Clinical IT Platform and the expected benefits of the Common Clinical IT Platform to a regional Health Information Exchange ("HIE").

INDEX OF DOCUMENTS:

- Exhibit Q-2A High-Level Timeline for Common Clinical IT Platform
- Exhibit Q-2B Summary Description of Parties Current Electronic Health Records Systems and Plans for Common Clinical IT Platform
- Exhibit Q-2C Ballad Health Alignment Overview IT Strategy

In addition to the above information, see **Exhibit Q-1A** previously referenced for information about MSHA's current electronic health records system.

[58] This timeline was also attached as Exhibit 22A to the Authority Responses.
[59] The information was also attached as Exhibit 22B to the Authority Responses.

V.Q.4.

4. Provide documents relating to any plans to create the Common Clinical information technology (IT) platform, including any internal analyses and consultant reports.

JOINT RESPONSE: See **Exhibit Q-1A** previously referenced. The New Health System has committed to propose implementation milestones for the Common Clinical IT Platform to the Commonwealth no later than three months after the closing of the merger or June 30, 2017, whichever is later. The New Health System will report in each annual report its progress toward implementing the Common Clinical IT Platform, and after implementation, any material enhancements or changes. The New Health System will also include in the annual report to the Commonwealth the researchers (by individual or by group for those working together) who have entered into Business Associate Agreements for purposes of conducting research.

V.Q.5.

5. **Provide documents relating to any culture audits and any governance studies or audits conducted internally or externally, including the ultimate findings and any consultant reports.**

MSHA RESPONSE: **Exhibit Q-5A** contains MSHA documents relating to any culture audits and any governance studies or audits conducted internally or externally, including the ultimate findings and any consultant reports.

MSHA believes that **Exhibit Q-5A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit Q-5A MSHA Culture & Governance Assessment – **PROPRIETARY**

WHS RESPONSE: **Exhibit Q-5B** contains WHS documents relating to any culture audits and any governance studies or audits conducted internally or externally, including the ultimate findings and any consultant reports.

WHS believes that **Exhibit Q-5B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit Q-5B WHS Culture & Governance Assessment – **PROPRIETARY**

V.Q.6.

6. **Provide documents relating to MSHA's and WHS' use of tele-medicine in the area, including grant money obtained to develop and deploy such systems.**

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibits Q-6A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit Q-6A MSHA System Virtual Health Business Plan and Telehealth Inventory Feb. 2016 – **PROPRIETARY**
- Exhibit Q-6B MSHA Current Use of Telemedicine and Telemedicine Grants

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibits Q-6D, 6E, 6F and 6G** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit Q-6C WHS Description of Telemedicine Activities
- Exhibit Q-6D WHS Description of WHS Telepsych – **PROPRIETARY**
- Exhibit Q-6E WHS Draft Flow Chart – **PROPRIETARY**
- Exhibit Q-6F WHS Patient Information and Consent for Telepsy Draft – **PROPRIETARY**
- Exhibit Q-6G WHS The Use of Telepsychiatry Policy Draft – **PROPRIETARY**

JOINT RESPONSE: Telemedicine will play a significant role in NHS' transition into an efficient, high quality, and accessible health care delivery system. As illustrated by the Parties' Exhibits, the Parties currently utilize telemedicine. MSHA, for example, recently entered into a partnership with eMD Anywhere to bring telemedicine services into schools to support school nurses. By December 31 of 2016, the service will be available in 81 Tennessee schools. Research is currently being completed to assess the laws regarding provision and reimbursement of telemedicine in Virginia, with a particular focus on Medicaid. If Virginia laws, licensure and reimbursement policies support rural telemedicine, the plan is to approach Southwest Virginia school districts to begin operations in the 2017-2018 school year.

Through the Cooperative Agreement, the New Health System will be capable of expanding the use of telemedicine to great effect in the region. This expanded use will play a significant role in pediatrics. By collaborating, NHS will be able to expand the program for access to pediatric sub-specialty care via telemedicine initiated at Norton Community Hospital Emergency Room to the entire Southwest Virginia region. NHS' multi-faceted strategy of telemedicine, rotating clinics, training and support of general pediatricians, targeted placement of local behavior health practitioners, and use of other licensed professionals is critical to meet the needs of children in Southwest Virginia.

V.Q.7.

7. **For MSHA and WHS list the existing hardware (major components) and existing software licenses by IT Vendor for hospital, outpatient, and physician information systems. Detail which hardware and software capabilities of the system are available in each Virginia facility. Provide copies of major systems software license agreements.**

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibits Q-7A and 7B** are proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit Q-7A MSHA List of Hardware, Software Licenses– **PROPRIETARY**
- Exhibit Q-7B MSHA Major Software License Agreements - **PROPRIETARY**

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibits Q-7C, 7D, 7E, 7F, 7G, 7H, 7I, 7J and 7K** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit Q-7C WHS 3M Software License Agreement– **PROPRIETARY**
- Exhibit Q-7D WHS Master Installment Payment Agreement– **PROPRIETARY**
- Exhibit Q-7E WHS List of Hardware and Software Inventory– **PROPRIETARY**
- Exhibit Q-7F WHS EPIC License and Support Agreement– **PROPRIETARY**
- Exhibit Q-7G WHS EPIC Systems Corporation Amendment to License– **PROPRIETARY**
- Exhibit Q-7H WHS McKesson Contract Supplement– **PROPRIETARY**
- Exhibit Q-7I WHS McKesson Amendment– **PROPRIETARY**
- Exhibit Q-7J WHS MModal Master Agreement– **PROPRIETARY**
- Exhibit Q-7K WHS VMWARE Agreement– **PROPRIETARY**

V.Q.12.

12. **Please provide the FTE operating and capital statistics for any regional data center located in Virginia during the five (5) year historical period and YTD. Detail the benefits. Provide these data for the five (5) year forecast period. If no Virginia regional data center exists or is proposed please explain why.**

JOINT RESPONSE: Neither MSHA nor WHS has operated a regional data center in Virginia during the periods requested. There are four primary factors that potentially obviate the need for regional data centers.

- Standardized enterprise applications: As the industry moves more and more to truly integrated software platforms possessing sufficient capacity to bear the processing and performance burdens of very large enterprises it naturally becomes less and less necessary to co-locate an instance of an application within a specific region.

- Virtualized server technology: With the advent and proliferation of virtual server technology, IP telephony, and TCP/IP networking protocols highly centralized data processing environments are now possible and considered industry best practice. The Applicants' Virginia hospitals (except Dickenson County) have basic virtual server infrastructure and resources (frames and VMs) either onsite or supported by the corporate data centers. Local resources are a direct extension of our primary enterprise data center and are on premise as a future proofing strategy in the event we require local workload processing. The local VMs provide the capability to handle local processing and future application requirements incompatible with industry standard centralized processing methods and protocols.

- Geographic compactness: The geographical closeness of the Applicants' facilities is well suited for our centralized computing model, no long haul networking is required to connect to our facilities. This geographic compactness will allow the NHS to establish high speed data interconnects between all our facilities including a centralized data center.

- Robust bandwidth and vendor diversity Wide Area Network (WAN) availability: Due to the diversity of internet service vendors and the robust nature of data capacities available the Applicants are able to very quickly adjust bandwidth needs by geographic location, specific location, or building as the needs fluctuate.

In addition to the technical factors mentioned above the NHS will consist of two complete state-of-the-art information technology infrastructures located currently in Tennessee, which when combined and reconfigured will be the most cost effective way to meet the future computing needs of the new enterprise. There is not a need to construct an additional new data center elsewhere in the Southwest Virginia-Northeast Tennessee region.

V.Q.13.

13. Explain your approach to the investment in high tech information systems jobs in Southwest Virginia.

JOINT RESPONSE: The savings generated by the merger efficiencies will enable the NHS to make substantial investments in providing new health care services, which will create job opportunities. Shifting physical resources and personnel away from unnecessary inpatient services to needed outpatient services (including mental health and substance abuse services), case management services, and health management services will ultimately result in a healthier population and contribute to economic improvement, including a more sustainable health care workforce and a more employable overall workforce. It is foreseeable, but not assured, that there could be high tech information system jobs created in Virginia as a result of new services and models of care under the NHS.

In addition to jobs associated with new services mentioned above, the NHS will invest in academic and research programs that attract talent throughout the region in Virginia and Tennessee. The NHS commits to increase residency and training slots, create new specialty fellowship training opportunities, and add faculty. The NHS intends to attract and retain employees by being competitive with neighboring health systems. The Parties believe that by carrying through on the commitments in the Application, the NHS will become a nationally recognized model which will attract highly talented team members and physicians who want to be part of a health care solution not necessarily offered elsewhere. The merger and these investments by the NHS will have an overall positive economic impact on the region.

V.S.1.

S. Salaries

1. **Please provide a listing of the highest paid 100 employees in Virginia and in Tennessee for each Applicant showing name, gender, race, ethnic background, job title and annual salary, benefits and bonuses during the two (2) year historical baseline period.**

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibit S-1A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit S-1A MSHA Top 100 Paid Employees - **PROPRIETARY**

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibit S-1B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit S-1B WHS Top 100 Paid Employees - **PROPRIETARY**

V.T.5.

5. **Identify any potential disadvantages that may result from the Cooperative Agreement in detail for each Virginia facility.**

   JOINT RESPONSE: The requested information is provided.

   INDEX OF DOCUMENTS:

   - Exhibit T-5 Potential Disadvantages that may result from the Cooperative Agreement

V.T.13.

13. Provide the total amount detailed in the reports from MSHA and WHS, referenced in the Master Affiliation Agreement Section 10.04(d), setting forth all expenses incurred by the parties. Include justification for the above amount. Detail all additional merger-related expenses, including capital costs and management costs. Provide documentation of the availability of the necessary funds.

JOINT RESPONSE: The Parties' combined expenses associated with the Cooperative Agreement and the TN COPA as of November 30, 2016 are set forth below. The Parties have not incurred any capital costs related to the merger. The management, staff and board members of both Parties have spent thousands of hours working on the potential merger, but this time is not accounted for separately. All expenses related to the merger are paid on a monthly basis.

Expense Category	Expense Incurred as of November 30, 2016
Communication Services	$1,529,106
Consulting Services	$2,600,860
Cooperative Agreement and TN COPA Fees*	$341,997
Due Diligence Services	$2,815,329
Legal Services	$11,710,559

*Cooperative Agreement and TN COPA Fees include the filing fees and expenses that have been paid to the Southwest Virginia Health Authority and the Tennessee Department of Health. This amount does not reflect the $50,000 application fee that was paid recently to the Virginia Department of Health.

V.T.21.

21. Provide the report prepared by FTI Consulting, Inc., i.e., the report that details the assumptions used in calculating the proposed economies and efficiencies of the proposed merger.

JOINT RESPONSE: The report prepared by FTI Consulting, Inc., including its assumptions used in calculating the proposed economies and efficiencies of the proposed merger, is included in **Exhibit M-3C**, previously referenced.

V.T.26.

26. `Provide all documents relating to the opposition mounted by MSHA to prevent WHS from constructing a new hospital facility and emergency room in Washington County where MSHA operates its Johnson City hospital.

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibit T-26** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit T-26 MSHA Documents Relating to Opposition of WHS COPN Application in Washington County, VA – **PROPRIETARY**

V.T.30.

30. Should the Lee County Hospital Authority fail to complete its project to reopen the former Lee Regional Medical Center as a critical access hospital, how do the applicants plan to meet the health care needs of the people in Pennington Gap and the surrounding area?

JOINT RESPONSE: As of this time, the Lee County Hospital Authority has announced that it signed a letter of intent with a for-profit entity, Americore Health, to provide emergency services in the former Lee Regional Medical Center facility with the intent to apply for the necessary approvals to open a critical access hospital.[64] Other nearby NHS hospitals will remain available to meet the health care needs of these patients.

The New Health System commits 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. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the NHS, and continued investment in health care and preventive services based on the demonstrated need of the community. The NHS may adjust scope of services or repurpose hospital facilities. In the event that the New Health System repurposes any hospital, it will continue to provide essential services in the community. If the New Health System becomes the primary health service partner of the Lee County Hospital Authority, the New Health System will be responsible for providing "essential services" as outlined below. For purposes of this commitment, the following services are considered "essential services"

- 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 behavioral health network of services through a coordinated system of care; and

[64] *See* http://www.wcyb.com/news/virginia/lee-county/lee-county-finds-manager-for-shuttered-hospital/104495803.

- Community-based education, prevention and disease management services for prioritized programs of emphasis based on goals established in collaboration with the Commonwealth of the Authority.

V.T.35.

35. Provide a monetary value to the merger versus continued individual operation of the two systems.

JOINT RESPONSE: Please see the combined revenues for the new system shown in the FTI Report (**Exhibit M-3C**).

V.T.36.

36. Provide a complete copy of the "FTI" report.

JOINT RESPONSE: **Exhibit M-3C** contains a complete copy of the FTI Report.

LIST OF EXHIBITS FOR RESPONSE #3

SECTION V

Exhibit Number	**Description**
D-1	Virginia Patient DRGs for Tertiary Hospitals
D-3	Market Share Tertiary Service in Virginia Counties
J-1A	MSHA Virginia Health Insurance Relationships ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
M-3A	Joint Contact Information for FTI Consulting, Inc.
M-3B	Joint NewCo Baseline Financial Model Information
M-3C	Joint NewCo Baseline Financial Model Information and Report of FTI Consulting, Inc. ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
M-7A	MSHA FY13-14 and FY14-15 Charge Masters ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
M-8A	MSHA Current Charge Master ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
M-14A	MSHA Utilization and Revenue Stats for Virginia Facilities ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**

M-15A	MSHA Utilization and Revenue Stats for Tertiary Hospital ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
M-16A	MSHA Utilization and Revenue Stats for Uninsured Patients-Virginia ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
M-17A	MSHA Utilization and Revenue Stats for Charity Care Patients_Virginia ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
Q-1A	MSHA HIS Report ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
Q-2A	High-Level Timeline for Common Clinical IT Platform
Q-2B	Summary Description of Parties Current Electronic Health Records Systems and Plans for Common Clinical IT Platform
Q-2C	Ballad Health Alignment Overview IT Strategy
Q-5A	MSHA Culture & Governance Assessment ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**

Q-6A	MSHA System Virtual Health Business Plan and Telehealth Inventory Feb. 2016 ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
Q-6B	MSHA Current Use of Telemedicine and Telemedicine Grants
Q-7A	MSHA List of Hardware, Software Licenses ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
Q-7B	MSHA Major Software License Agreements ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
S-1A	MSHA Top 100 Paid Employees ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
T-5	Potential Disadvantages that may result from the Cooperative Agreement
T-26	MSHA Documents Relating to Opposition of WHS COPN Application in Washington County, VA ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**

TERTIARY DRG DETAIL 11 COUNTY VA MARKET AREA					
FACILITY	DRG	DRG DESCRIPTION	FY14	FY15	FY16***
Sentara Norfolk General H	220	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC		1	1
	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC		1	
	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	1		
	473	CERVICAL SPINAL FUSION W/O CC/MCC	1		
	507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC		1	
	683	RENAL FAILURE W CC		1	
	709	PENIS PROCEDURES W CC/MCC	1		
	238	MAJOR CARDIOVASC PROCEDURES W/O MCC	1		
	65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1		
	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1		
Grand Total			**6**	**4**	**1**

VA, TN, NC State IP Data Through CY 2015

*** **NOTE: FY16 REPRESENTS ONLY THE LAST TWO QUARTERS OF 2015.**

Exhibit D-3 Market Share Tertiary Service in Virginia Counties

DATA SOURCE: VHHA, THA and NC State databases.

DISCHARGES WITH RELATIVE WEIGHTS of >2.0**

SYSTEM	FACILITY	2013	2014
Wellmont	WELLMONT BRISTOL REGIONAL MEDICAL CENTER	1,876	1,817
	Wellmont Holston Valley Medical Center	1,498	1,453
	WELLMONT LONESOME PINE HOSPITAL	62	74
	MOUNTAIN VIEW REGIONAL MEDICAL CENTER	102	63
	LEE REGIONAL MEDICAL CENTER	26	
	Wellmont Hancock County Hospital		1
Wellmont Total		**3,564**	**3,408**
All Other	CARILION MEDICAL CENTER	459	444
	Mission Hospital	148	335
	UNIVERSITY OF VIRGINIA MEDICAL CENTER	283	336
	CLINCH VALLEY MEDICAL CENTER	375	330
	The NC Baptist Hospitals		
	Pikeville Medical Center	180	213
	WYTHE COUNTY COMMUNITY HOSPITAL	199	160
	CARILION NEW RIVER VALLEY MEDICAL CENTER	88	118
	Duke University Med Ctr		
	Novant Health Forsyth MC		
	Vanderbilt University Medical Center		
	Blue Ridge Regional Hosp		
	LEWISGALE MEDICAL CENTER	39	51
	University of Tennessee Medical Center	32	50
	UK Chandler Medical Center	23	17
	Fort Sanders Regional Medical Center	12	12
	BUCHANAN GENERAL HOSPITAL	24	30
	LEWISGALE HOSPITAL - PULASKI	17	21
	Carolinas Medical Center	3	19
	TWIN COUNTY REGIONAL HOSPITAL	26	41
	LEWISGALE HOSPITAL - MONTGOMERY	16	17
	Novant Hlth Charlotte Ort		
	MCV HOSPITALS OF VCU MEDICAL CENTER	17	14
	East Tennessee Children's Hospital	8	10
	Middlesboro ARH Hospital	4	6
	Parkwest Medical Center	10	5
	Claiborne Medical Center	4	6
	Hugh Chatham Mem Hospital		
	CARILION TAZEWELL COMMUNITY HOSPITAL	5	3
	St. Jude Children's Research Hospital	1	18
	Duke Raleigh		3
	INOVA FAIRFAX HOSPITAL	5	2
	Hazard ARH Regional Medical Center	2	1

Baptist Health Lexington	1	1
UVA TRANSITIONAL CARE HOSPITAL	2	2
Watauga Medical Center	6	3
Park Ridge Health	3	1
UNC Hospitals	6	
Harlan ARH Hospital		7
SENTARA MARTHA JEFFERSON		1
Methodist Medical Center of Oak Ridge	1	1
Davis Medical Center	1	2
Select Specialty Hospital		
Blue Ridge HealthCare NC		
Northern Hosp-Surry Cnty		
Duke Regional Hospital	1	2
MEMORIAL HOSPITAL	1	
Tug Valley ARH Regional Medical Center		
Margaret R Pardee Mem		
Asheville Specialty Hosp		
Whitesburg ARH Hospital	1	2
INOVA MOUNT VERNON HOSPITAL		
CARILION GILES MEMORIAL HOSPITAL		2
UK Healthcare Good Samaritan Hospital	2	2
Frye Regional Med Center		
BON SECOURS ST. MARY'S HOSPITAL		1
Saint Joseph East		4
CJW MEDICAL CENTER	1	2
Saint Joseph Hospital	11	4
CMC - Pineville		
TRISTAR CENTENNIAL MEDICAL CENTER	1	1
SENTARA VIRGINIA BEACH GENERAL HOSPITAL		
Novant Helth Rowan MC		
Lake Norman Reg Med Ctr		
CENTRA HEALTH	1	
MedWest Harris		
Novant Hlth Presbyterian		
Caldwell Memorial Hosp		
Onslow Memorial Hospital		
TRISTAR SOUTHERN HILLS MEDICAL CENTER		1
CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS		
NC Specialty Hospital		
Parkridge Medical Center		
CMC-Northeast		
HENRICO DOCTORS' HOSPITAL	2	2
NOVANT HEALTH PRINCE WILLIAM MEDICAL CENTER		
High Point Regional Hosp		
SENTARA WILLIAMSBURG REGIONAL MEDICAL CENTER	2	
Rex Healthcare		
Kindred Hospital-Chattanooga		

RIVERSIDE REGIONAL MEDICAL CENTER	1	
TriStar Skyline Medical Center		
Cape Fear Valley Hlth Sys		
Catawba Valley Medical		
Cone Health	1	4
LeConte Medical Center	1	1
Saint Joseph Hospital London		1
New Hanover Regional M.C.		
Saint Thomas West Hospital	3	1
CENTER FOR RESTORATIVE CARE AND REHABILITATION	1	
CarolinaEast Medical Ctr		
VALLEY HEALTH WINCHESTER MEDICAL CENTER		1
Select Specialty Hospital - Lexington		
WakeMed		1
Alleghany Memorial Hosp		
SENTARA NORFOLK GENERAL HOSPITAL	1	4
Wilkes Regional Med Ctr		
MARY WASHINGTON HOSPITAL		2
Alamance Regional Med Ctr		
VIRGINIA HOSPITAL CENTER	1	
Duke University Medical Center	44	66
BON SECOURS MEMORIAL REGIONAL MEDICAL CENTER	1	2
Catawba Valley Medical Center	1	1
Mercy Hospital	8	
Norton Brownsboro Hospital	1	
Lake Norman Regional Medical Center		2
Norton Hospital	1	1
Carolinas HealthCare System Charlotte Institute of Rehab		1
Norton Womens and Kosair Childrens Hosp		1
Memorial Health Care System (Hospital)	3	
Novant Health Charlotte Orthopedic Hospital	4	7
Mission Health System	139	
Ashe Memorial Hospital		1
New Hanover Regional Medical Center	2	1
Novant Health Forsyth Medical Center	17	51
SENTARA PRINCESS ANNE HOSPITAL		1
Novant Health Medical Park Hospital		2
Carolinas HealthCare System Carolinas Medical Center	6	
Novant Health Presbyterian Medical Center		4
BON SECOURS ST. FRANCIS MEDICAL CENTER	1	
Blount Memorial Hospital		1
Medical Park Hospital	1	
Cape Fear Valley Health System	1	
University of Louisville Hospital	1	1
High Point Regional Hospital	3	1
First Health Moore Regional Hospital	2	
Blue Ridge HealthCare Hospitals Inc		2

	Forsyth Memorial Hospital	27	
	Hugh Chatham Memorial Hospital	10	10
	CaroMont Health Inc.	1	
	Our Lady Of Bellefonte Hospital	2	
	BON SECOURS MARY IMMACULATE HOSPITAL	2	1
	INOVA ALEXANDRIA HOSPITAL		1
	SENTARA NORTHERN VIRGINIA MEDICAL CENTER		1
	INOVA FAIR OAKS HOSPITAL		1
	Columbus Regional Healthcare System	1	
	Alleghany Memorial Hospital	1	1
	Shriners Hospital for Children Lexington	1	1
	Asheville Specialty Hospital	1	1
	The McDowell Hospital	1	
	Presbyterian Orthopaedic Hospital	2	
	The North Carolina Baptist Hospital	242	240
	Randolph Hospital	1	
	Carolinas Medical Center Northeast	2	
	Iredell Health System		2
	Durham Regional Hospital	3	
	Jackson-Madison County General Hospital	1	
	Carolinas Specialty Hospital	2	
	Kindred Hospital - Chattanooga	1	
	ERLANGER MEDICAL CENTER	2	
	Kindred Hospital Louisville		1
	University of North Carolina Hospitals	2	1
	Kindred Hospital of Greensboro	3	
	Erlanger Medical Center-Baroness Hospital		1
	Saint Thomas Midtown Hospital	2	2
	VALLEY HEALTH WARREN MEMORIAL HOSPITAL	1	
	Blue Ridge Regional Hospital	47	47
	Vanderbilt University Hospitals	67	48
	Kindred Hospital-Greensboro	1	
	Vidant Medical Center	3	
	Select Specialty Hospital - Greensboro	2	
	Morristown-Hamblen Healthcare System	4	1
	Kings Daughters Medical Center	2	1
	AUGUSTA HEALTH		1
	Select Specialty Hospital - Winston-Salem	2	
	Northern Hospital of Surry County	1	2
	Select Specialty Hospital of Winston Salem		5
	Margaret R. Pardee Memorial Hospital	2	
All Other Total		**2,710**	**2,833**
MSHA	JOHNSTON MEMORIAL HOSPITAL	664	806
	Johnson City Medical Center	782	831
	Indian Path Medical Center	394	358
	NORTON COMMUNITY HOSPITAL	169	226
	SMYTH COUNTY COMMUNITY HOSPITAL	113	146

	RUSSELL COUNTY MEDICAL CENTER	40	26
	Franklin Woods Community Hospital	7	9
	Unicoi County Memorial Hospital, Inc.	3	
	Sycamore Shoals Hospital		3
MSHA Total		**2,172**	**2,405**
Grand Total		**8,446**	**8,646**

2015
1,717
1,393
138
3,248
493
343
303
258
240
229
187
135
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** Includes the Following VA Counties:

Buchanan
Dickenson
Grayson
Lee
Russell
Scott
Smyth
Tazewell
Washington
Wise
Wythe

CY15 DISCHARGES

NHS	5791	67.1%
OTHER	2840	32.9%
TOTAL	8631	

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2,840
1,016
832
342
180
145

18
8
1
1
2,543
8,631

FACILITIES LISTED IN THE QUESTION		
CARILION MEDICAL CENTER	493	
UNIVERSITY OF VIRGINIA MEDICAL CENTER	303	
CARILION NEW RIVER VALLEY MEDICAL CENTER	135	
MCV HOSPITALS OF VCU MEDICAL CENTER	13	
CARILION TAZEWELL COMMUNITY HOSPITAL	7	
INOVA FAIRFAX HOSPITAL	5	
UVA TRANSITIONAL CARE HOSPITAL	5	
INOVA MOUNT VERNON HOSPITAL	2	
SENTARA VIRGINIA BEACH GENERAL HOSPITAL	1	
SENTARA WILLIAMSBURG REGIONAL MEDICAL CENTER	1	
SENTARA NORFOLK GENERAL HOSPITAL	1	
TOTAL	**966**	
TOTAL VISITS TO NON NHS FACILITIES	2,840	
TOTAL VISITS TO LISTED FACILTIES	966	34.0%

Exhibit XI-3A

JOINT - Contact Information regarding Baseline Financial Model

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Exhibit 9.1

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 XI-3B

JOINT - PUBLIC

Report of FTI Consulting, Inc.
and NewCo Baseline Financial Model

The following documents have been prepared by FTI and submitted as part of the application process for a cooperative agreement in Virginia and a COPA in Tennessee. The documents are included in **Exhibit XI-3B**.

1) **Original Description of FTI Analysis – February 16, 2016 to SWVHA**
   - This was submitted on February 16, 2016 to the Southwest Virginia Health Authority ("SWVHA") as Exhibit 9.1 to the Cooperative Agreement Application – Five Year Projected Budget for New Health System. Exhibit 9.1 is public information.
   - Exhibit XI-3B includes this original description of FTI Analysis (Application Exhibit 9.1).

2) **Updated FTI Baseline Financial Model – July 13, 2016 to TN DO**H
   - In a letter dated April 22, 2016, the Tennessee Department of Health ("TN DOH") commented on the financial model:

     > The "Timing and Phases of Efficiency Assumptions" section stated that no efficiency savings are projected to be implemented in whole or in part until the FYE6/17; however, the "Preliminary Efficiencies" Model Income Statement appeared to reflect savings of $41,144 over the "Baseline" model for the FYE 6/16 (i.e., savings of $21,632 in medical supplies and drugs, $5,651 in purchased services, $1,002 in maintenance and utilities, and $12,859 in other).
   - In order to address the TN DOH comment, FTI updated the timing in the second run of the model to start FYE 6/17, which reflects the current anticipated timeline.
   - Description of change made to the model: For the forecasted columns of the "Baseline" Model Balance Sheet, the assumptions in the baseline were that the Company post-merger would have to payout each Joint Venture entity's interest, while currently the separate hospitals do not appear to make those distributions and allow each Joint Venture entity to maintain the cash balance. The total net asset balances reported in the Baseline Model Balance Sheet in the 2016 through 2020 columns have been updated to match the baseline assumption, that the Joint Venture entities do not make distributions and retain the cash.
   - The Parties' written response to the TN DOH comment:

     > The "Timing and Phases of Efficiency Assumptions" description included savings that could be negotiated on day one. Since these contract changes would occur at the start of the merger FTI assumed the impact would be immediate. In the "Baseline" model, FTI has updated the timing in the second run of the model to start FYE 6/17 which reflects the current anticipated timeline. The updated Financial Model is attached as Exhibit 35.
   - This response and the updated financial model were submitted on July 13, 2016 to the TN DOH as part of the Parties' responses to the TN DOH letter dated April 22, 2016. The response and Exhibit 35 are public information.
   - Exhibit XI-3B includes this July updated version of the NewCo Baseline Financial Model.

Exhibit 22A: High-Level Timeline for Common Clinical IT Platform

d. Common Clinical IT and Health Information Exchange	Year 1				Year 2				Year 3				Year 4				Year 5				Year 6				Year 7				Year 8				Year 9				Year 10			
Tenn. Comp. R. & Regs. 1200-38-01-02(2)(a)10	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
i. System Integration 18-24 months																																								
Assessment of Health Systems including vendor		X	X																																					
System Implementation with data conversion and 3rd party interfaces				X	X	X	X	X	X	X	X	X																												
Training all Users (employed & non-employed providers)									X	X	X	X																												
1. Behavioral Health Capability												X																												
EMR systems include: - Standardized screening questionnaires & assessment tools - Clear and consistent documentation protocols - Treatment plans, flowsheet & restraint documentation - Suicide intervention tools																																								
Integration and interoperability follows the standard for an integrated EMR, which is fully integrated and interoperable.																																								
EMR system will have future development for a behavioral health module																																								
2. Integration											X	X																												
Large EMRs interface with over fifty 3rd party vendors, linking records, integrating lab, medical, diagnostic, referral, and scheduling. Interfaces are inbound and outbound, to and from vendors, providers, government entities, etc.																																								
3. Migration of Historical Data										X	X	X																												
Historical data such as medications, allergies and problems lists are generally converted to the new system. The remaining historical data will be accessible through a link inside the EMR to an archiving system such as DataArk (used at Wellmont.)																																								
4. Training of New Users									X	X	X	X																												
All employed and non-employed providers are required to attend a minimum of 8 hours classroom training and pass a test to gain access to the EMR. Surgeons /proceduralists/specialists require additional training time. Training is specialty specific and includes a personalization lab.																																								
5. Patient Portal Access												X																												
5.1 Medications, allergies, problem list, immunization records, test results, visit/admission summaries, e-visits, billing information with the capability to pay online as well as patient engagement: such as clinical offerings to healthy behavior classes, research studies, patient education are available through a patient portal.																																								
5.2The patient portal also links to other vendor enabled health systems.																																								
5.3 Patients have access to reconciled health care data from different health systems.																																								
6. Collecting, Analyzing and Reporting Quality Outcomes													X																											
Data is sent monthly to various analytical companies including Crimson, Comparion and CMS providing statistical analysis for clinical cost, quality, and patient satisfaction for both system and non system providers.																																								

Exhibit 22A: High-Level Timeline for Common Clinical IT Platform

d. Common Clinical IT and Health Information Exchange	Year 1				Year 2				Year 3				Year 4				Year 5				Year 6				Year 7				Year 8				Year 9				Year 10			
Tenn. Comp. R. & Regs. 1200-38-01-02(2)(a)10	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ii $150 Million Investment																																								
1. Common Clinical IT Platform - $148m * This initiative provides the platform for both the common clinical IT solution and connectivity for health information exchange, population health management and quality measurement reporting. This creates the connected community of hospitals and care givers, providing patients full access to their personal health record.		X	X	X	X	X	X	X	X	X	X	X	X																											
a. Health information exchange - Wellmont's health information exchange plan includes, regional, domestic, and international capabilities. Currently Wellmont is exchanging on all three.														X																										
b. Quality reporting capabilities														X																										
c. Population Health Management														X																										
d. Connectivity for non system providers (current state)														X																										
2. EHR solution for non-system providers $2m*					X																																			
*Cost for the Common Clinical IT Platform will include, but not limited to, the following:																																								
-Hardware: new and upgrades																																								
-Software: new and upgrades																																								
-3rd party interfaces																																								
-Licensing fees																																								
-Post implementation annual maintenance fees																																								
-Vendor implementation fees																																								
-Consulting fees																																								
-Labor																																								
-Training/training related materials																																								
-Go-live support																																								
iii Regional Health Information Exchange	X																																							
Wellmont's participation in OnePartner/HIE will be fully operable June 23, 2016. MSHA is currently participating in OnePartner. It is expected that the New Health System will meaningfully participate in a health information exchange.																																								

Exhibit XV-2B

- **Description of the Parties' Plans for Electronic Health Records Systems**

A. Wellmont currently uses Epic (2014 version) as its enterprise-wide electronic health record solution. It includes the enterprise system to support the workflows for all clinical areas (acute hospitals and outpatient centers), ambulatory clinics and urgent care centers, as well as the access and revenue system for financial and billing functions. This results in one record for each patient regardless of where he/she is seen within the Wellmont system.

B. Mountain States currently employs multiple Meaningful Use Stage 2 certified technologies to support health care services in the region.

(i) Ambulatory. The ambulatory space is based on the AllScripts Touchworks Electronic Health Record version 11.4.1 hf20 with a planned upgrade to 15.1 scheduled for August 2016. This system supports:

- Problems, Allergy, Medication, and Immunization recoding and communication
- Electronic Medication Prescribing (drug / allergy interaction checking)
- Physician Order Entry
- Physician documentation at point of care
- Electronic lab and radiology resulting
- Electronic document imaging
- Intersystem Communication
- Integrated patient portal supporting scheduling and clinical interaction
- Patient Education

(ii) Acute. Additionally, Mountain States utilizes the Cerner Soarian Version 4.0.15 system for the acute setting. Major functions include:

- Full integrated legal electronic health record
- Problem, allergy, medication, and immunization capture and communication
- Medication administration assurance
- Clinician clinical documentation
- Clinical order entry
- Integration with clinical design and administration (IMRT, Critical Care)
- Digital radiology capture and communication
- Integrated lab result communication
- Intersystem communication

The Ambulatory and Acute systems work as a cohesive unit, supporting all aspects of care across the continuum of Mountain States' integrated healthcare delivery network.

- **Description of plan to convert to a single records system if the New Health System is approved**

  If the Cooperative Agreement is approved, the Parties expect the New Health System to assess each Party's existing electronic health records computer platform(s), including third party systems, hardware, software, computer infrastructure, etc., to determine the roadmap to bring the New Health System onto a Common Clinical IT Platform, as described in the Application.

  This assessment is expected to take at least six months after the New Health System is formed. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, a high-level timeline for implementation of the Common Clinical IT Platform is included as **Exhibit 22.1** to these Responses. Major categories of the implementation costs would include, but not be limited to, the following:

  (i) Hardware: New and Upgrades
  (ii) Software: New and Upgrades
  (iii) 3rd Party Systems and Interfaces
  (iv) Licensing Fees
  (v) Vendor Implementation Fees
  (vi) Consulting Fees
  (vii) Labor Costs
  (viii) Training/Training Related Materials
  (ix) Go-Live Support
  (x) Post-Implementation Annual Maintenance Fees
  (xi) Any Future Additions of EMR Applications

- **Expected Features and Benefits of the Common Clinical IT Platform.**

  The Common Clinical IT Platform that the New Health System adopts will allow providers in the New Health System to quickly obtain full access to patient records at the point of care and will be used for system-wide communication and monitoring of best practices and establishment of new protocols to improve quality of care. Specifically, the Common Clinical IT Platform is expected to result in a "One Patient-One Record" platform where all health information will be located on one system. The Parties intend for the Common Clinical IT Platform to include the following features:

  A. Log inpatient visits, emergency department visits, outpatient visits, ambulatory clinic visits, urgent care visits, and any visit within the New Health System.
  B. When a physician views a patient record, he/she will be able to see ALL encounters the patient has had anywhere in the system. This will be available to both employed and non-employed physicians.
  C. The data will include all physician notes, nurses notes, therapy notes, all other clinical specialty notes, history/physical, discharge summaries, lab, radiology and other diagnostic reports, allergies, medications, problem lists, radiology images, photos of wounds and other physical notations as surgical photos, all physician

orders placed, protocols used for treatment, patient data from other locations where the patient may have been treated, links to evidence based literature articles as reference and patient education materials.

D. The physician will also be able to link out to past medical records of the patient in the previous EMR system, so he/she does not need to go back to another system to see the patient's history.
E. Future appointments can be made as well as referrals to specialists.
F. Follow up letters to referring physicians can be generated within the Common Clinical IT Platform and sent directly from the Common Clinical IT Platform.
G. Results from outpatient testing will be delivered to the physician's in-basket to allow review of the results as soon as they are completed.
H. Actual radiology/cardiology images can be viewed by the physician within the EMR without going to another system to see the image or to the Radiology Department to view.
I. Patient results can be graphed or charted so trends can be viewed.
J. Data reports can be generated to determine the quality of the care being delivered, which allows for peer review as required by accrediting agencies.
K. Physicians can document the ICD-10 diagnoses with accompanying details for Meaningful Use purposes as required by CMS.
L. Best practice alerts will notify the physician/clinical staff if the patient is at risk for certain issues, medication interactions, falls risk, and numerous other safety features.
M. The order sets will include all orders that are required by CMS and other regulatory agencies as well as best practice guidelines to assure the patient is receiving the best and safest care.
N. Physician notes can be dictated directly into the EMR, saving transcription and reporting time, so the notes are available immediately to any consulting physician or clinical staff.

The Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care. Additionally, the Platform will be used to facilitate the increased adoption of best practices and evidence-based medicine implemented by the New Health System. The New Health System intends to use the Common Clinical IT Platform to provide immediate system-wide alerts and new protocols to improve quality of care. This will enable the New Health System to reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

- **Expected Benefits of the Common Clinical IT Platform to the Regional Health Information Exchange (HIE).**

While the Common Clinical IT Platform will offer many benefits to patient care within the New Health System, not all providers in the region will be on the same IT platform as the New Health System and may not be able to share data with the New Health System. Historically, EHRs built by different vendors lacked transmission standards for exchanging patient data between healthcare entities. This meant that many EHR

systems could not exchange data outside of their own private networks. The HIE is a way of sharing electronic health information among doctors' offices, hospitals, labs, radiology centers, outpatient centers, and other health organizations. Both Mountain States and Wellmont currently participate in an existing HIE in the region, as described below, and the Parties believe the functionality of this HIE or another can be significantly improved through the expanded use of the HIE through the region and the more detailed and meaningful data the New Health System will be able to contribute as a result of its Common Clinical IT Platform. Better communication of patient data and best practices via a thriving regional HIE will improve patient care and lower cost of care. The New Health System is committed to participating meaningfully in the enhancement of a regional HIE.

The Common Clinical IT Platform is designed to facilitate the sharing of electronic health information across the New Health System, while the HIE will allow the New Health System to share electronic health information with participating providers across the region and nation - regardless of their affiliation with the New Health System.

The New Health System desires to support an HIE that will allow the doctors and nurses treating patients in a hospital or doctor's office to access the patient's medical history from any provider connected to the HIE. For example, an independent primary care doctor can review recent lab results whether the test was conducted at an independent specialist's office, at a New Health System hospital, or at a third-party participating lab. Because all authorized doctors and medical personnel will see the same health information through the HIE, this will help to reduce any errors, avoid unneeded duplication of tests and procedures, and consequently, could reduce medical bills.

A key distinction between the Common Clinical IT Platform and HIE is the information available to providers when accessing a medical record. While a provider on the Common Clinical IT Platform will be able to pull up the patient's entire medical history contained in the patient record, the information available within an HIE is typically limited to certain fields that are most commonly used or accessed by providers. This information is typically limited to the following fields:

- Name
- Demographics
- Active Allergies
- Current Medications
- Problem List (Current Problems)
- Problem List (Resolved Problems)
- Recent Visits
- Immunizations
- History (Medical and Surgical)
- History (Family)
- History (Social)
- Last Recorded Vital Signs
- Progress Notes
- Plan of Care

- Functional Status
- Recent Results
- Primary Care Physician
- Custodial/Source Organization

Because the HIE is primarily designed to share information across multiple EHR systems in small and large settings, not all of the Common Clinical IT Platform features are available to providers using the HIE. For example, the Common Clinical IT Platform is expected to include the following features that are not typically included in HIE capabilities:

- Helping providers more effectively diagnose patients, reduce medical errors, and provide safer care through evidence-based tools built into the Common Clinical IT Platform
- Improving patient and provider interaction and communication, as well as health care convenience, by enabling electronic communications between providers and patients (e.g. secure messaging)
- Enabling safer, more reliable prescribing by enabling electronic transmission of prescriptions from provider offices to pharmacies
- Helping promote legible, complete documentation and accurate, streamlined coding and billing
- Reducing costs through decreased paperwork, improved safety, reduced duplication of testing, and improved health
- Enabling providers to improve efficiency and meet their business goals, improve productivity and work-life balance.

As health care moves from fee-for-service to value-based care, the sharing of clinical data for outcomes and accountable care will be very important both within the New Health System and across various health care organizations. The New Health System believes that the significant financial investments it is making to adopt a Common Clinical IT Platform will bring significant benefits for all patients seeking care within the New Health System. The New Health System's commitment to meaningfully participate in an HIE ensures that the health care data collected within the New Health System will be accessible by all participating providers across the region and nation. These two commitments taken together have the potential to drastically improve the quality of care offered across the region.

Ballad Health Alignment Overview
7. 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.

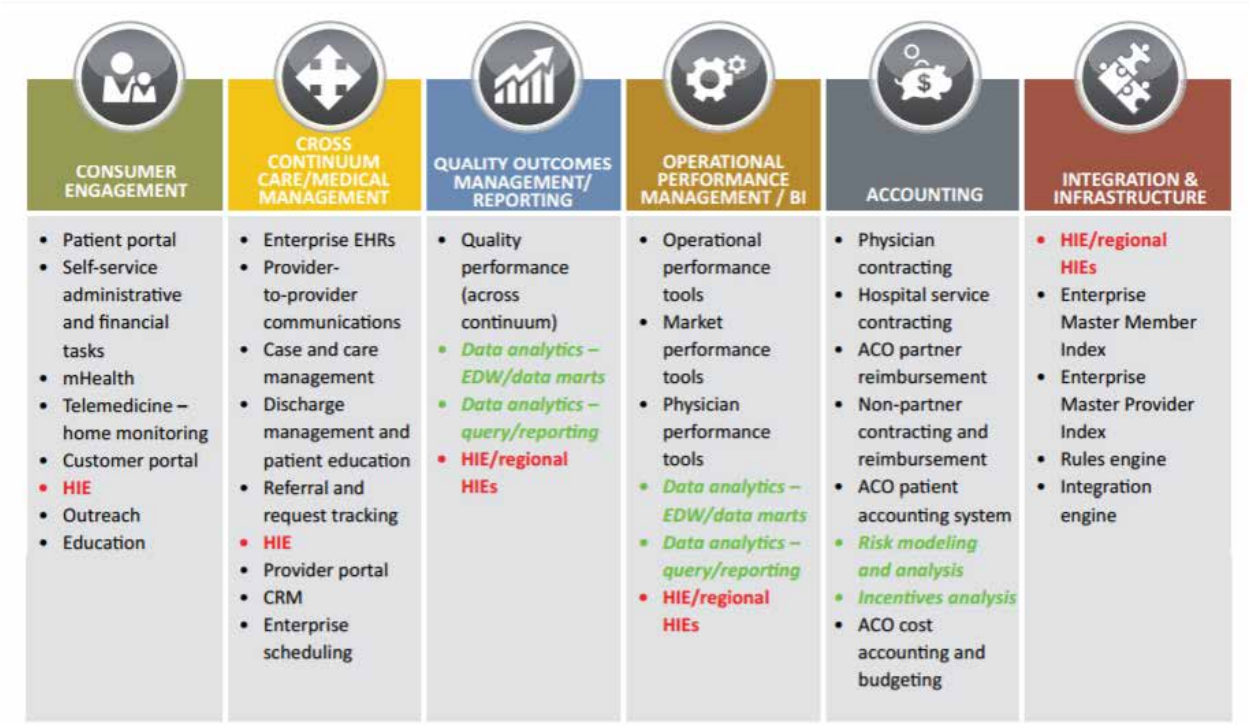
A. IT Assessment

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.

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[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

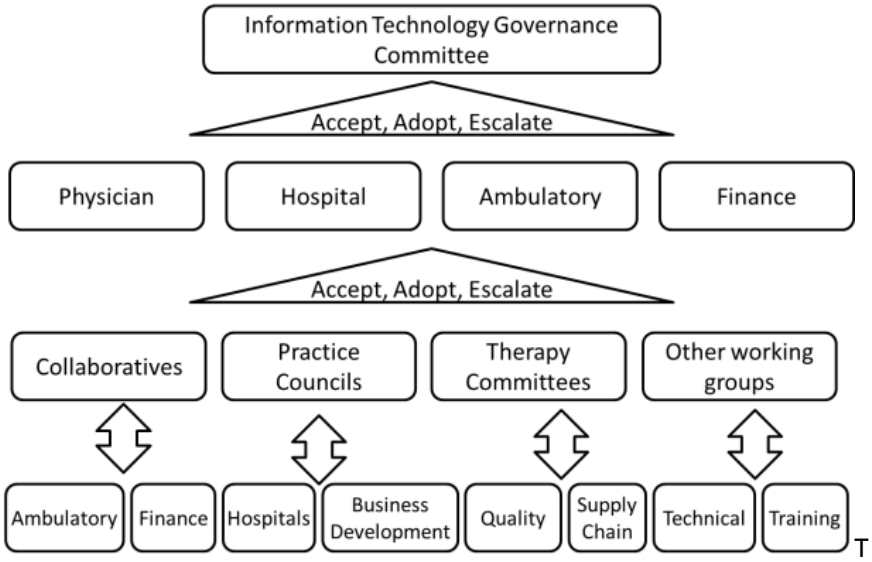
IT governance will be the critical link between business strategy and IT systems for value creation. The overarching Ballad Health population health strategy will drive the transformation, and the IT systems support the clinical and business functions of the organization. To achieve this strategy/support 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* Section #2, 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.

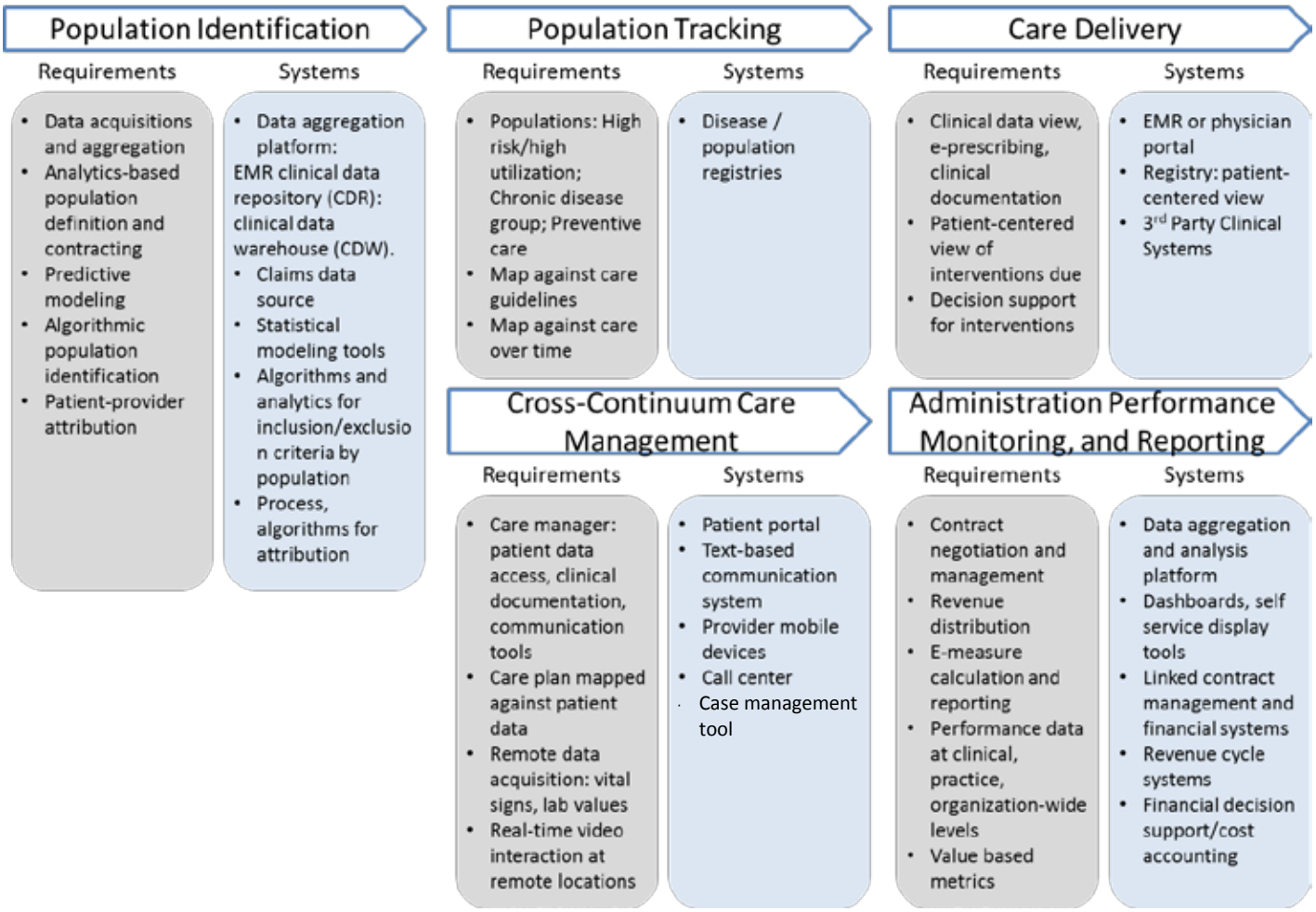


III. Roadmap for Implementation

If the CA 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 Commonwealth 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 Virginia Department of Health Questions dated December 22, 2016, Exhibit Q-2A.
[5] *See* Responses to Virginia Department of Health Questions dated December 22, 2016, Exhibit O-5C.


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

Description of MSHA's Current Use of Telemedicine
July 29, 2016

Mountain States Health Alliance ("MSHA") is engaged in several active telemedicine initiatives. The following list presents a brief telemedicine services inventory per facility/entity. Additionally, a table is provided that will further detail activity by facility.

Johnson County Community Hospital

JCCH is currently our most active user of telemedicine services. To service psychiatric patients in its emergency room, JCCH is conducting committal assessments internally to Woodridge Psychiatric Hospital. JCCH also completes pediatric consults from its emergency room to Niswonger Emergency Department providers. Furthermore, JCCH completes case management assessments for patients via telemedicine with its internal case managers. The hospital staff also uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients.

JCCH's outpatient clinic completes geriatric psychiatric, osteopathy, pulmonology, cardiology, & pediatric visits via telemedicine with East Tennessee State University providers. The outpatient clinic also completes diabetes assessments, pre-assessment surgery consults, and congestive heart failure follow up's via telemedicine.

Sycamore Shoals Hospital

SSH currently provides psychiatric committal assessments internally to Woodridge Psychiatric Hospital. SSH also completes pediatric consults from their emergency room to Niswonger Emergency Department providers. SSH uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients. Lastly, SSH connects with Vanderbilt Neurology to provide neurology assessments in the emergency room.

Unicoi County Medical Hospital

UCMH currently provides psychiatric committal assessments in its emergency room internally to Woodridge Psychiatric Hospital. UCMH also completes pediatric consults from its emergency room to Niswonger Emergency

Department providers. UCMH also completes case management assessments for patients via telemedicine with its internal case managers. Lastly, UCMH uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients.

Johnson City Medical Center

JCMC currently obtains psychiatric committal assessments internally to Woodridge Psychiatric Hospital via telemedicine. JCMC uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients. Lastly, JCMC connects with Specialist On-Call (a third party vendor) to provide neurology assessments in the emergency room for additional neurology coverage.

Niswonger Children's Hospital

NsCH currently obtains psychiatric committal assessments internally to Woodridge Psychiatric Hospital via telemedicine. NsCH uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients. Lastly, in conjunction with other MSHA facilities, NsCH emergency physicians provide pediatric telemedicine consults to outlying facility emergency departments.

Woodridge Psychiatric Hospital

WPH currently provides committal assessments internally to all of MSHA's Tennessee hospitals via telemedicine. WPH uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients.

Franklin Woods Community Hospital

FWCH currently provides psychiatric committal assessments internally to Woodridge Psychiatric Hospital. FWCH uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients. Lastly, FWCH connects with Vanderbilt Neurology to provide neurology assessments in the emergency room.

Indian Path Medical Center

IPMC currently obtains psychiatric committal assessments internally to Woodridge Psychiatric Hospital via telemedicine. IPMC uses the Language Line

telemedicine service to assist with hearing impaired and language impaired patients. Lastly, IPMC connects with Specialist On-Call (a third party vendor) to provide neurology assessments in the emergency room for neurology consults.

Johnston Memorial Hospital

JMH currently uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients. Johnston Memorial providers provide dietician services via telemedicine for some of MSHA's outpatient clinics in Norton (VA) and Johnson County (TN).

Russell County Medical Center

RCMC currently uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients. RCMC currently provides telemedicine services to geriatric psychiatric patients from the provider.

Smyth County Community Hospital

SCCH currently uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients.

Norton Community Hospital

NCH completes pediatric consults from its emergency room to Niswonger Emergency Department providers. NCH uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients. Lastly, NCH obtains neurology consults for emergent patients in the emergency room by connecting with University of Virginia.

NCH's outpatient clinic utilizes diabetes dietary consults via telemedicine with Johnston Memorial outpatient providers.

Dickenson County Hospital

DCH completes pediatric consults from its emergency room to Niswonger Emergency Department providers. DCH uses the Language Line telemedicine service to assist with hearing impaired and language impaired patients. Lastly, DCH provides providers services in its inpatient geriatric unit via providers from Woodridge Psychiatric Hospital.

DCH's outpatient clinic provides intensive geriatric outpatient services to its patients via telemedicine with the East Tennessee State University psychiatric office.

2016 Telemedicine Initiatives In-Progress

Niswonger Children's Hospital, in conjunction with MSHA First Assist Urgent Care providers, is in the process of implementing school-based telemedicine with eight school systems in the region. This project will begin rollout in August 2016 and will continue through December 2016. MSHA has partnered with eMDAnywhere, which has partnerships with each of the school systems in which we are providing this service.

Niswonger Children's Emergency Department is implementing emergent pediatric consults to all of the MSHA rural emergency rooms. With four MSHA emergency departments already online (NCH, DCH, JCCH, and SSH), the implementation will continue to roll-out to the remaining facilities every 30 days and is scheduled to be completed by the end of 2016.

Additionally, MSHA has been awarded two Distance Learning & Telemedicine ("DLT") grants from the U.S. Department of Agriculture. These grants allow us to purchase technology which will enable telemedicine connections to our rural hospitals from our tertiary hospital and our specialists' offices. The first DLT grant, already in progress, is focused on emergency department and inpatient telemedicine efforts and should be completed by end of 2017. The second grant, which was just awarded in July 2016, will focus specifically on intensive care unit ("ICU") telemedicine efforts and will begin implementation phase in 2017. These ICU telemedicine efforts will continue through the life of the grant, which ends in 2019.

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Telemedicine Grants January 1, 2010 to May 23, 2016						
Year	Facility	Grant Number	Grant Name	Description	Amount	Funding Agency
2014	UCMH	GR-16-45137-00	Small Hospital Rural Improvement Program (SHIP)	Purchased Envoate Telemedicine cart set up- List of items included if requested	$ 8,698.56	TN Department of Health
2015	UMCH	Z1713035100	Small Hospital Rural Improvement Program (SHIP)	Applied funding to the purchase of an AVIZIA cart	$ 8,375.00	TN Department of Health
2014	JCCH	GR-16-451121-00	Small Hospital Rural Improvement Program (SHIP)	Purchased Envoate Telemedicine cart set up- List of items included if requested	$ 8,724.00	TN Department of Health
2015	JCCH	DG-16-130037-00	Small Hospital Rural Improvement Program (SHIP)	Applied funding to the purchase of an AVIZIA cart	$ 8,375.00	TN Department of Health
2015	DCH	OMHHE-2016-0008	Small Hospital Rural Improvement Program (SHIP)	Applied funding to the purchase of an AVIZIA cart	$ 7,537.44	VA Department of Health
2015	NCH	OMHHE-2016-0011	Small Hospital Rural Improvement Program (SHIP)	Applied funding to the purchase of an AVIZIA cart	$ 7,537.44	VA Department of Health
2015	RCMC	OMHEE-2016-	Small Hospital Rural Improvement Program (SHIP)	Applied funding to the purchase of an AVIZIA cart	$ 7,537.44	VA Department of Health
2015	SCCH	OMHHE-2016-0019	Small Hospital Rural Improvement Program (SHIP)	Applied funding to the purchase of an AVIZIA cart	$ 7,537.43	VA Department of Health
2014	MSHA	TN0723-B17	Distance Learning and Telemedicine Grant	Purchased (9)Envoate Telemedicine cart set up- List of items included if requested and applied funding to the purchase of an AVIZIA Telemedicine cart s	$ 169,200.00	USDA - Rural Utility Services
2015	MSHA	NONE	Hearst Foundation	Applied funding to the purchase of 8 AVIZIA carts	$ 75,000.00	The Hearst Foundations
				Total	**$ 308,522.31**	

EXHIBIT XVI-5
POTENTIAL DISADVANTAGES

The following is an evaluation of any potential disadvantages of the proposed merger along with the mechanisms we have set forth to address and mitigate them. This evaluation applies overall to the New Health System and individually to its component entities, including the Virginia hospitals.

(A) The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers;

Background: Depending on the facts, mergers can "enable the merged firm to reduce its costs and become more efficient, which, in turn, may lead to lower prices, higher quality products [or services], or investments in innovation."[1] Also under certain facts, mergers can result in market power, which can be exercised by raising price, reducing quality or slowing innovation.[2] The Cooperative Agreement law's list of potential disadvantages reflects this principle as well.

Assessment: While anticompetitive effects may be a disadvantage resulting from some unregulated mergers, even if such effects were otherwise likely here, the Virginia General Assembly, through the Cooperative Agreement, as implemented under the Rules and Regulations Governing Cooperative Agreements, provides the Department with an effective means to address this potential disadvantage by actively supervising the payer contracts entered into by the merged entity.

The major payer mix for the proposed Geographic Service Area of the New Health System (Application Exhibit 15.1-C) is:

Medicare	38.6%
Medicaid	17.0%
Medicare Advantage	14.7%
Commercial	17.5%
Self-Pay	6.2%

Because fee-for-service Medicare and Medicaid payments to hospitals are established by formula and largely unaffected by price competition, the principal category of payers that could potentially be disadvantaged by a merger are commercial health plans and their enrollees (including Medicare and Medicaid managed care). These payers also represent a substantial share of total enrollment in the Virginia and Tennessee service area, respectively. As such, it is important for the Parties to be included in contracts with each of these payers.

The combined inpatient share in the proposed Geographic Service Area for the New Health System is approximately 73 percent. The combined facilities share for outpatient services (Application Exhibit 14.1-A to 14.1-D) ranges between 0% and 55.6% depending on the specialty. Combined, the New

[1] Commentary on the Horizontal Merger Guidelines, Federal Trade Commission and U.S. Department of Justice (2006) at 1, available at https://www.ftc.gov/sites/default/files/attachments/merger-review/commentaryonthehorizontalmergerguidelinesmarch2006.pdf.
[2] Id.

Health System will employ approximately 30% of the physicians in the proposed Geographic Service Area.

The Parties recognize that absent the active supervision of a Cooperative Agreement, there is a concern that the New Health System could potentially be able to obtain increased prices from non-governmental payers for whom prices are subject to negotiation. The Parties believe that the current and future market conditions in which the New Health System operates impose both substantial constraints on their pricing and quality and incentives to achieve improved outcomes. Among these are the relatively small proportion of patients covered by commercial contracts relative to Medicare, Medicaid, and other non-commercial or uninsured business, and the substantial share of enrollment held by the New Health System's largest two payers. The New Health System will have every incentive to negotiate with these payers in order to be able to attract patients and avoid loss of patients to other hospitals. In addition, as noted elsewhere, the Parties have committed to invest significantly in the communities in which they operate in the form of new services, enhanced services and locations, programs and initiatives to improve population health, and targeted investments on the highest priority health issues. These provide the incentive to achieve efficiencies and to improve health and outcomes, so as to sustain investments.

Nonetheless, there are certain mechanisms that the Parties have proposed that could be adopted by the Commonwealth to actively supervise the payer contracts entered into by the merged entity to address this potential disadvantage.

Recommendation: In order to prevent the New Health System's ability to exercise any increased market or bargaining power achieved through the merger that could adversely impact the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals or other health care providers, the Parties, in consultation with the Southwest Virginia Health Authority ("Authority"), have proposed that the following commitments be included in the Cooperative Agreement and be actively supervised by the Commonwealth:

1. *In order to minimize any adverse impact on the ability of insurance companies to contract with the hospitals, and while this Cooperative Agreement ensures open access and choice for all consumers to choose any hospital in the region, it also remains the intent of the Cooperative Agreement that consumers and businesses enjoy a competitive market for insurance. As such, the New Health System will negotiate in good faith with Principal Payers[3] to include the New*

[3] For purposes of this Application, "Principal Payers" are defined as those commercial payers and governmental payers with negotiated rates who provide more than two percent (2%) of the New Health System's total net revenue. (All of a payer's revenue shall be considered in calculating the revenue percentage even if the payer has more than one contract with the New Health System.) The proposed commitments would not apply to traditional Medicare or any other payers that provide two percent (2%) or less of the New Health System's net revenue. Notwithstanding any provision to the contrary, the limitation on rate increases applicable to insurers providing coverage on behalf of governmental payers (i.e., Medicare Advantage Plans or Medicaid Plans) does not apply if the adjustments are tied to actions made by government entities, including but not limited to, market basket adjustments, adjustments tied to area wage index, or other governmentally imposed rate adjustments. The limitations on pricing committed to by the parties are intended to ensure price increases beyond the limits imposed by the Cooperative Agreement do not occur as a result of increased market concentration resulting from the merger transaction. The price limits imposed by the Cooperative Agreement are not intended to interfere with government-imposed pricing which would occur with or without the creation of the New Health System. To

Health System in health plans offered in the Geographic Service Area on commercially reasonable terms and rates (subject to the limitations herein). The New Health System will not unreasonably refuse to negotiate with potential new entrants to the market or with insurers that do not meet the definition of "Principal Payer", as long as the payer has demonstrable experience, a reputation for quality fair-dealing and timely payment, and negotiates in good faith. New Health System will resolve through mediation any disputes as to whether this commitment applies to the proposed terms of a health plan contract. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this commitment if the payer has insureds (or members) in the Commonwealth of Virginia, and shall offer to the Commissioner updates on the progress of such mediation.

How this commitment would prevent the potential disadvantage: This commitment by the New Health System would prevent the New Health System from rejecting in-network participation for payers constituting more than two percent of the New Health System's revenue if terms and rates offered were commercially reasonable (a judgment itself subject to the Commonwealth's active supervision). Because the New Health System would be required to negotiate in good faith with all Principal Payers who offer commercially reasonable terms, or risk violation of the terms of the Cooperative Agreement, the New Health System would have no leverage to demand anticompetitive rates. This commitment would be actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance and by evaluating any complaints from affected payers, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement. In addition, any disputes in health plan contracting between the New Health System and the Principal Payers would be subject to mediation. Mediation consists of confidential negotiations facilitated by a third-party neutral whose role is limited to helping parties arrive at a mutually agreeable resolution to the dispute. Mediation is less expensive than litigation and less time-consuming. The Parties believe the commitment to mediation will help expeditiously resolve any disputes that arise with Principal Payers in order to minimize the impact a dispute may have on covered beneficiaries.

2. *In order to ensure providers in the region not affiliated with the New Health System may continue to operate competitively, and to ensure new provider entrants to the market are not disadvantaged by the New Health System, the New Health System will not require as a condition of entering into a contract that it shall be the exclusive network provider to any health plan, including any commercial, Medicare Advantage or managed Medicaid insurer. Nothing in this commitment shall be construed as to impede the discretion of the payers in the market from designating the New Health System (or components thereof), as an exclusive network provider in all or part of the New Health System's service area.*

How this commitment would prevent the potential disadvantage: This commitment would prevent the New Health System from requiring payers to contract with the merged entity exclusively in the proposed Geographic Service Area. The result is that consumers will continue to have network choices beyond the New Health System and providers will have an alternative to contracting solely with the New Health System or its network. This commitment would be

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the degree pricing for insurers providing coverage on behalf of governmental payers is tied contractually to Medicare rates (i.e., a percent of Medicare), the Cooperative Agreement is not intended to interfere with such pricing relationships. The intent is to ensure future pricing is not increased as a result of the merger transaction.

actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance, which would be easily verifiable, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

3. *The New Health System will not engage in "most favored nation" pricing with any health plans.*

   How this commitment would prevent the potential disadvantage: A most-favored- nation clause is any term in an agreement between a payer and a provider that stipulates that either a) the provider give the payer the lowest rate that it contracts with any comparable payer or b) the payer must give the provider the highest rate that it contacts with any comparable provider. This commitment will preclude the New Health System from obtaining a promise from a health plan that it will be paid as much as, or more than, any other provider with which the health plan contracts. Such a commitment controls the New Health System's ability to exercise any alleged market or bargaining power achieved through the merger to require payers to pay them the highest price available in the market. Alternatively, where a large payer may require the lowest possible rate contracted in the market from the New Health System, this commitment would prevent a scenario whereby the New Health System is reluctant to offer discounts to other payers. Such activity could prevent other, possibly more competitive, payers from effectively competing in the market. This commitment would be actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance, which would be easily verifiable, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

The Parties believe that including these commitments in the Cooperative Agreement will prevent the New Health System from exercising any possible market or bargaining power achieved through the merger to adversely impact the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals or other healthcare providers. The Parties presume that, to ensure the disadvantage is prevented, the Commonwealth will actively supervise these commitments through annual reporting requirements.

(B) The extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement;

Background: Depending on the facts, consolidation between health system competitors could result in a net benefit for patients, employers and payers by fostering integrative efficiencies, realignment of resources and improved opportunities for value-based care and population health improvement. In a given case, the elimination of competition between merging parties could also facilitate market power to engage in exclusionary practices that foreclose other healthcare providers or suppliers from access to the market and lead to increased prices for consumers.

Assessment: Although the merger will eliminate competition between the Parties, the Cooperative Agreement is the mechanism created by the Virginia General Assembly to allow beneficial mergers while ensuring through active Commonwealth supervision that consumers retain those benefits. Through this statutory authority, the Commonwealth is able to protect its citizens from

anticompetitive activity and simultaneously allow the New Health System to address the region's major population health issues and related healthcare challenges.

As noted above, the combined facilities share for outpatient services (Application Exhibit 14.1-A through 14.1-D) ranges between 0% and 55.6% depending on the specialty. Combined, the New Health System will employ approximately 30% of the physicians in the proposed Geographic Service Area (Application Exhibit 14.1-E). The merger of Mountain States and Wellmont will not create a concentrated market involving any physician or outpatient services. The Parties acknowledge that for general acute care inpatient services, the merger creates a relatively concentrated proposed Geographic Service Area.

Without active supervision under the authority of the Cooperative Agreement law, it is possible the merger would empower the New Health System through exclusionary practices to foreclose market access by physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals. There are, however, certain mechanisms that the Parties have proposed that could be adopted by the Commonwealth to actively supervise the merger and ensure that consumers reap the expected benefits of higher-quality, more affordable care from the merger.

Recommendation: In order to prevent the New Health System from reducing competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals in a way that is likely to result in disadvantages, the Parties, in consultation with the Authority, have proposed that the following commitments be included in the Cooperative Agreement and be actively supervised by the Commonwealth:

1. *In order to ensure choice of providers for consumers and to ensure physicians are free to practice medicine without any adverse effect from the merger, the New Health System will maintain an open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital departments or services as determined by the New Health System's Board of Directors or the hospital board if the hospital board is acting as the ultimate fiduciary body.*

   How this commitment would prevent the potential disadvantage: A commitment to maintain an open medical staff at all facilities will ensure equal access to all qualified physicians in the proposed Geographic Service Area according to the criteria of the medical staff bylaws. This will ensure that independent physicians who meet the rules and conditions of the organized medical staffs of each facility will not be disadvantaged compared to physicians employed or contracted by the New Health System. This commitment would be actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance, which would be easily verifiable, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

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

   How this commitment would prevent the potential disadvantage: Independent physician practices frequently depend on the ability to see patients at multiple facilities to provide services or manage populations for whom they've assumed risk. A commitment to abstain from

exclusive contracting for certain non-hospital-based physician services will enable independent physician practices to continue to compete with physicians employed or contracted by the New Health System. The New Health System will restrict any exclusive contracting to certain hospital-based physicians, like hospitalists, radiologists, pathologists, or emergency-room physicians, as approved by the Board of Directors. The best practice in the industry for preserving quality and managing cost in these hospital-based departments is for such services to be managed by a single physician group, with such group being held to standards determined by the leadership of the hospital in collaboration with the group. As an example, it would not be optimal for a hospital to have multiple ER physician groups staffing the ER, laboratory or radiology, as doing so would risk confusion and lack of consistency in processes. This is why exclusive contracts for hospital-based physicians are common in hospital markets of any concentration level. For independent physician groups that provide hospitalist services, the New Health System will continue to allow the independent physicians or their hospitalists to follow their patients in multiple hospitals as long as the independent physicians meet the organized medical staff rules and conditions and the metrics related to performance on which the hospital and independent practice agree. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the Commonwealth through annual reports attesting to compliance and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

3. *In order to ensure physicians and patients maintain their choice of facilities, and to ensure independent physicians can maintain their independent practice of medicine, the New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities.*

   How this commitment would prevent the potential disadvantage: Exclusive contracting has the potential to reduce competition by requiring physicians to render services only at facilities of the New Health System. Restricting the practice of independent physicians to the New Health System's hospitals and other facilities has the potential to reduce the number of referrals in the proposed Geographic Service Area available to competing providers, and reduce the labor supply of physicians necessary for these providers to operate in the market. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the Commonwealth through annual reports attesting to compliance and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

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

   How this commitment would prevent the potential disadvantage: Prohibiting or disincentivizing independent physicians from participating in health plans and provider networks of their choice has the potential to reduce competition and raise prices for insurers contracting to form provider networks. A commitment to not engage in such practices (be they as conditions for obtaining privileges or for other reasons) ensures continued competition among health plans and providers. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the Commonwealth through annual reports attesting to compliance, which would be easily verifiable, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

5. *In order to improve quality for patients, ensure seamless access to needed patient information, and to support the efforts of the local physician community to access needed information in order to provide high quality patient care, the New Health System will participate meaningfully in a health information exchange or a cooperative arrangement whereby privacy protected health information may be shared with community-based providers for the purpose of providing seamless patient care.*

   How this commitment would prevent the potential disadvantage: A health information exchange built off a Common Clinical IT Platform has the potential to improve coordination of care and quality of health care services across the region. To ensure that independent physicians and other health care providers in the proposed Geographic Services Area will not be disadvantaged by lack of access to patient information necessary for the management of their patients, the New Health System has committed to invest up to $6 million over 10 years participating in a health information exchange open to community providers. The New Health System will ensure its Common Clinical IT Platform interfaces appropriately with the exchanges designed to share health information such that data may be shared with physicians. Additionally, the New Health System will utilize the data for its own employed physicians and service locations where the use of this data will enable improvement in the coordination of care. The New Health System will report annually to the Commissioner on mileposts toward meeting this commitment. This commitment would be actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance once the health information exchange is fully established and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

6. *In order to enhance quality and decrease the total cost of care, the New Health System will collaborate in good faith 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 to deliver such outcomes at the highest possible value.*

   How this commitment would prevent the potential disadvantage: A clinical services network would allow for the standardization of clinical practice policies and procedures to promote efficiency and higher standards of care. By standardizing practices, models, and protocols, the instances of clinical variation and overlap would be lessened, the length of stay would be shortened, costs would be reduced, and patient outcomes would be improved. The New Health System would work with a physician-led Clinical Council to identify best practices to be used to develop standardized practice models and protocols. The Clinical Council would be composed of independent physicians and physicians employed by the New Health Systems or its subsidiaries or affiliates. This commitment would be actively supervised by requiring the New Health System to report every milepost towards meeting this commitment to the Commissioner.

7. *In order to enhance hospital quality, improve cost-efficiency, improve the utilization of hospital-related services, and to enhance opportunities in research, the New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. The New Health System will make access to the IT Platform available on reasonable terms to all physicians in the service area. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, and*

post-acute care and outpatient services and facilitate the move to value-based contracting. Subject to confidentiality laws and rules, the New Health System will grant reasonable access to the data collected in its Common Clinical IT Platform to researchers with credible credentials who have entered into Business Associate Agreements for the purpose of conducting research in partnership with the New Health System.

How this commitment would prevent the potential disadvantage: The adoption of a Common Clinical IT Platform will facilitate a community health information exchange between participating community providers in the region. This exchange will help ensure that providers have the information they need to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. By having access to the IT Platform, all physicians within the service area will have access to this information. The integrated IT Platform will enable patient information to be more portable, removing barriers to patient choice and improving patients' access to their own health information. The New Health System will invest up to $150 million dollars towards developing and instituting the Common Clinical IT Platform. This commitment will be actively supervised through reports to the Commissioner for every delineated milepost, as well as annual reports to the Commissioner of the progress towards implementing the IT Platform, any material enhancements or changes that occur after integration, and a report of the researchers that entered into Business Associate Agreements.

8. *In order to enhance access to services for patients, and to ensure robust choices remain in the market for physicians in the various specialties needed throughout the region, the New Health System will commit to the development of a comprehensive physician/physician extender needs assessment and recruitment plan every three years in each community served by the New Health System. The New Health System will consult with the Authority in development of the plan. The New Health System will employ physicians and physician extenders primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding. The New Health System will promote recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment.*

   How this commitment would prevent the potential disadvantage: By working with independent physician groups, as well as the Authority, the New Health System will help expand access to care and the availability of services in underserved areas and locations. Utilizing additional physicians and physician extenders in those areas will increase employment opportunities in the service area. The New Health System also commits to build relationships with existing physician groups and providers to improve the availability of the missing specialty to patients in the region. The New Health System will report to the Commissioner within a year of the closing of the merger, and thereafter, every three years, on the progress towards recruitment goals.

9. *In order to ensure employees are properly recognized for their years of service, and to protect the benefits they have earned over time, the New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will provide all employees credit for accrued vacation and sick leave.*

   How this commitment would prevent the potential disadvantage: A health system that

achieves increased market share or bargaining power through a merger could potentially obtain labor at more favorable terms and wage rates than in an otherwise competitive market for the purchase of labor. Such an outcome is not likely for the New Health System due to at least two factors, in addition to this commitment: 1) the low area wage index that the region is currently assigned by the federal government creates competition for labor from outside the Geographic Service Area, and the merger will not reduce this competition; and 2) the New Health System will not have a dominant share in the outpatient and physician services market, which are attractive alternative employment options for hospital staff.

To further ensure that employees are not disadvantaged by the loss of competition between the Parties, the New Health System will commit to honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave. This commitment would be actively supervised by requiring the New Health System to file a report to the Commonwealth attesting to compliance after the first year after formation of the New Health System, which would be easily verifiable, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

The Parties believe that including these commitments in the Cooperative Agreement will prevent the New Health System, were it to obtain market power through the merger, from exercising it to reduce competition among or for physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals. To ensure the disadvantage is prevented, the Parties propose that the Commonwealth actively supervise these commitments through annual reporting requirements.

(C) The extent of any likely adverse impact on patients in the quality, availability, and price of health care services; and

Background: Depending on the facts, consolidation in health care markets can lead to substantial cost savings by eliminating costly duplication of services and equipment and improving quality of care. These benefits can manifest from an increase in the volume of services and ability to provide expanded and coordinated health care services throughout the region. Facts in a particular case can also show that such benefits are unlikely or insufficient to offset anticompetitive effects resulting from the elimination of competition between the parties. If population stagnation continues for the next five years, as current population trends for the region indicate, the reduced inpatient use rates and the downward pressure on reimbursement combined with the financial realities rural hospitals in both systems are facing, it is more likely that not consolidating will have a more adverse effect on both quality and access in those markets and be an outcome far inferior to the merger governed by a Cooperative Agreement. As stated in the Application, the Parties' rural hospitals are in peril, and the evidence shows that rural hospitals in general are at risk, especially in markets with declining population. As use rates decline for the larger tertiary hospitals - hospitals that also operate in markets experiencing population stagnation - it is increasingly unlikely that financial support for these rural hospitals can continue at the current rate. This will lead to reduced capitalization in those markets, and quality and access are likely to suffer. Conversely, as demonstrated within the multiple commitments being made within the Application, it is more likely that quality, availability and reduced pricing will only result from the approval of the Cooperative Agreement. Reduced pricing will occur for the uninsured through additional discounts on pricing in return for participation in organized care managed models of guaranteed access. Importantly, pricing will actually increase more for the insured population if the Cooperative Agreement is not granted, given the commitment to reduce pricing growth already

agreed to by payers, and subsequent limits on pricing growth thereafter.

Assessment: The merger will result in the consolidation of some services between the Parties, but not in any adverse impact on the quality, availability or price of health care services. The merger creates the opportunity to achieve significant cost-savings and other benefits for consumers. Active supervision through the Cooperative Agreement can preserve, and hold the New Health System accountable for enhancements in health care quality, cost-control, affordability, and access. Additional external pressures are also being placed on the health system to improve quality and reduce cost as well. For example, the Centers for Medicare and Medicaid Services has announced the imposition of value based purchasing and quality-based incentives and penalties for hospitals, which currently are focused on reduced readmissions, hospital acquired conditions, patient satisfaction and literally dozens of metrics which tie quality to reimbursement. Because the hospitals do not segregate populations as they work to comply with these mandates, all patients, regardless of payer, benefit from these efforts. Commercial, Managed Medicaid, and Medicare Advantage contracts are also significantly invested in pay-for- performance, and, in addition to active supervision, the New Health System will be held, through financial incentives and penalties, to achieving the objectives agreed to by the payer and the system. In addition, for the New Health System to achieve the expenditure commitments being made in the Application, pressure will exist to achieve the synergies committed in the Application. Significant competition will remain from large tertiary systems located nearby requiring the New Health System to continue to behave competitively to attract patients. Competition will remain locally in the outpatient marketplace. As a locally governed enterprise, accountability to the community will be an important advantage over the elimination of local governance which would occur if one or both of the Parties were to join out- of-market systems based elsewhere.

Therefore, as courts have recognized, the major changes occurring in the health care landscape require health systems to behave differently and to be responsive to these payer and government imposed performance standards. The consolidations occurring due to the merger better enable the system to achieve these objectives through improved efficiency, lower cost, and a refocusing of resources on the clinical integration necessary for success.

Recommendation: In order to prevent the New Health System from adversely impacting the quality, availability and price of health care services, the Parties have proposed that the following commitments be included in the Cooperative Agreement and be actively supervised by the Commonwealth:

1. *In order to preserve hospital services in geographical proximity to the communities traditionally served by such facilities, to ensure access to care, and to improve the utilization of hospital resources and equipment, all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. In the event that the New Health System repurposes any hospital, it will continue to provide essential services in the community. For purposes of this commitment, the following services are considered "essential services":*
   - *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.*

If the New Health System becomes the primary health service partner of the Lee County Hospital Authority, the New Health System will be responsible for essential services as outlined above.

How this commitment would prevent the potential disadvantage: In order to preserve hospital services in geographical proximity to the communities traditionally served by such facilities, to ensure access to care, and to improve the utilization of hospital resources and equipment, the New Health System will commit that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide at a minimum essential health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. This commitment ensures that health care access remains available in these communities. Each year, the New Health System will report to the Commissioner operating results for the Virginia hospitals and sites furnishing "essential services." The annual report to the Commonwealth will also outline services provided in each community by the hospitals or other sites furnishing "essential services" as specified in this commitment. This commitment would be actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance, which would be easily verifiable, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

2. *In order to ensure preservation of hospital facilities and tertiary services in geographical proximity to the communities traditionally served by those facilities, the New Health System will maintain, for the Virginia and Tennessee service areas, a minimum of the three full-service tertiary referral hospitals located in Johnson City, Kingsport, and Bristol, to ensure higher-level services are available in close proximity to where the population lives.*

How this commitment would prevent the potential disadvantage: In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. This commitment ensures that the three hospitals which have traditionally served as the hubs for high-level services, Johnson City Medical Center, Bristol Regional Medical Center and Holston Valley Medical Center, will remain available as tertiary referral centers to the patient population. The New Health System must report immediately to the Commissioner the closing of any of the above referenced three full-service tertiary referral hospitals and must also report any reduction in the capability of any of the three

tertiary referrals hospitals so that they can no longer be credibly viewed as tertiary referral hospitals. This commitment would be actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance, which would be easily verifiable, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

3. *In order to ensure choice of providers for consumers and to ensure physicians are free to practice medicine without any adverse effect from the merger, the New Health System will maintain an open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital departments or services as determined by the New Health System's Board of Directors or the hospital board if the hospital board is acting as the ultimate fiduciary body.*

   How this commitment would prevent the potential disadvantage: Under the current competitive system, patient choice is limited by restrictions on employed physicians' ability to practice at competing system's hospitals in the Geographic Service Area. With some exceptions, Wellmont-employed physicians are not allowed medical staff privileges at certain Mountain States hospitals and Mountain States-employed physicians are not allowed medical staff privileges at certain Wellmont hospitals. This is particularly true in highly competitive specialties such as cardiology. This practice exists because of competitive factors and does not support convenient access for patients. Not only will the New Health System maintain open medical staffs at all facilities, which allows patients to choose a physician and hospital based on their preferences and needs, but employed physicians will now be able to practice at all facilities within the New Health System subject to the rules and conditions of the organized medical staff of each facility. A commitment to maintaining an open medical staff at all facilities will ensure availability to all qualified employed, contracted or independent physicians in the proposed Geographic Service Area according to the criteria of the medical staff bylaws. This commitment would be actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance, which would be easily verifiable, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

4. *In order to ensure pricing is not increased as a result of the elimination of inpatient competition for the majority of consumers covered by third party commercial insurance, pricing will increase by less with the merger than if the merger were not to occur. For all Principal Payers,[4] the New*

[4] For purposes of this Application, "Principal Payers" are defined as those commercial payers and governmental payers with negotiated rates who provide more than two percent (2%) of the New Health System's total net revenue. (All of a payer's revenue shall be considered in calculating the revenue percentage even if the payer has more than one contract with the New Health System.) The proposed commitments would not apply to traditional Medicare or any other payers that provide two percent (2%) or less of the New Health System's net revenue. Notwithstanding any provision to the contrary, the limitation on rate increases applicable to insurers providing coverage on behalf of governmental payers (i.e., Medicare Advantage Plans or Medicaid Plans) does not apply if the adjustments are tied to actions made by government entities, including but not limited to, market basket adjustments, adjustments tied to area wage index, or other governmentally imposed rate adjustments. The limitations on pricing committed to by the parties are intended to ensure price increases beyond the limits imposed by the Cooperative Agreement do not occur as a result of increased market concentration resulting from the merger transaction. The price limits imposed by the Cooperative Agreement are not intended to interfere with government-imposed pricing which would occur with or without the creation of the New Health System. To the degree pricing for insurers providing coverage on behalf of governmental payers is tied contractually to Medicare rates

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. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement. Applicants represent that the fiscal year for the New Health System will end on June 30, and that the fiscal year will not change until after the second full year commencing after the closing date of the New Health System.

5. *To ensure the Cooperative Agreement protects consumers from pricing increases that could otherwise result from the elimination of competition, a limit on pricing growth is applied for each year to restrain pricing growth to below the national hospital consumer price index. Effective on the closing date of the merger, the New Health System will commit to not adjust hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This is a ceiling in rate adjustments; nothing herein establishes these adjustments as the floor on rates. To the extent, if any, that the Applicants negotiate contracts with Principal Payers between October 10, 2016 and the closing date of the merger and such contracts include fixed rate increases in excess of the hospital Consumer Price Index for hospital inpatient and outpatient services and the medical care Consumer Price Index for physician and non-hospital outpatient services compared with previous contracts with the same payer, no later than one month following the closing date, New Health System will rollback its rates to what they would have been if the negotiated rates of increase had been no more than the above-referenced Consumer Price Index changes. Applicants represent that their current contracts with Anthem for nongovernmental patients will not expire prior to the now-expected date of the rate increase commitment becoming effective, i.e., July 1, 2018.*

   <u>How these two commitments would prevent the potential disadvantage</u>: Without a commitment to cap rate increases, the New Health System could potentially use any marketing and bargaining power achieved through the merger to increase rates for payers and consumers. In order to prevent any potential disadvantage that may result for the patients and payers in the price of health care services, the Parties have proposed an initial rate reduction followed by a rate cap commitment to be supervised by the Commonwealth. Reducing existing commercial and Medicare Advantage contracted fixed rate increases by fifty percent (50%) for the second full fiscal year commencing after the closing date of the New Health System will lead to a reduction of prices for consumers and payers below that which is currently agreed to in contracts between Wellmont and its payers and Mountain States and its payers. The commitment of not increasing hospital, non-hospital and physician services rates greater than their respective Consumer Price Index minus 0.25% will bend the price curve, acting as a maximum cap on price growth that will always be lower than the national average. To ensure these commitments are implemented, the Commonwealth would actively supervise the rate cap implementation and the New Health System would be required by the Commonwealth to file an annual report attesting to compliance, which would be easily verifiable, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

(i.e., a percent of Medicare), the Cooperative Agreement is not intended to interfere with such pricing relationships. The intent is to ensure future pricing is not increased as a result of the merger transaction.

6. *In order to enhance quality, improve cost-efficiency and reduce unnecessary utilization of hospital services, for all Principal Payers, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.*

   How this commitment would prevent the potential disadvantage: Many of the Parties' commitments will allow the New Health System to achieve success as federal, Commonwealth and commercial payers increase their use of value-based payment. Among others, these include a common IT platform, more concentrated volumes, a goal of top decile performance, and a commitment to move toward risk-based models. Without the transaction, and with decreasing volumes and use rates (and thus an increasing inability to financially support many of the hospitals), it will simply be more difficult for these hospitals to achieve the objectives of the government and commercial payers.

   To ensure that a reduction in competition between facilities does not decrease the incentive for increased quality and value of care, the Parties have committed to seeking out the alignment of reimbursements with quality and value measures. Federal and Commonwealth governments are increasingly tying reimbursement, and reimbursement growth, to performance by measuring quality, patient experience and utilization/total cost of care. Commercial health plans and managed Medicare and Medicaid plans are following Medicare's lead. Not only will increased value based payments limit the ability of the New Health System to increase price based on a dominant market position, these payments will drive the New Health System towards improved quality and enhanced patient experience. Since an increasing number of payers with value-based systems reward appropriate utilization, it will be difficult for the New Health System to make up lost revenue from the price controls detailed above in items C.4 and C.5 by inappropriately increasing utilization. This commitment ensures that the New Health System will actively pursue quality and value based payments, and the Commonwealth will actively supervise this commitment by requiring the New Health System to report progress toward this goal on an annual basis, which will be easily verifiable.

7. *In order to enhance quality of patient care through greater transparency, improve utilization of hospital resources, and to ensure the population health of the region is consistent with goals established by the Authority, the New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers. Such reporting shall include posting of quality measures and actual performance on New Health System's website accessible to the public. The New Health System shall report such data timely so the public can easily evaluate the performance of the New Health System as compared to its competitors, and ensure consumers retain the option to seek services where the quality is demonstrably the highest. In addition, the New Health System will timely report and include on its web site its performance compared to the Medicare quality measures including readmission statistics. The New Health System will give notice to the Authority of the metrics the New Health System is prioritizing, and will, in good faith, include input from the Authority in establishing or modifying its priorities.*

   How this commitment would prevent the potential disadvantage: To further ensure that a reduction in competition between facilities does not decrease the quality of care in the

region, the New Health System will report quality measures in a timely and easy to understand manner for use by patients, employers and insurers. Public and proprietary reporting of quality data is increasingly being used by patients, employers and insurers to make decisions about what providers provide the best value. Not only are patients utilizing data on quality to decide what provider to use, employers and insurers are increasingly using similar quality data to decide how to tier or narrow their networks to incentivize the use of high-value providers or to exclude low-value providers all together. The Authority will have input on setting the priorities. This commitment ensures that the New Health System will be held accountable by the Commonwealth and the public for its quality performance. The Commonwealth will actively supervise this commitment by requiring the New Health System to comply with its quality reporting obligations on an annual basis, which will be easily verifiable.

8. *In order to ensure low income patients who are uninsured are not adversely impacted due to pricing, the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties and consistent with the Internal Revenue Service's final 501(r) rule. The New Health System shall furnish a copy of its policies relating to charity care to the Commissioner no later than the end of the third month following the closing of the merger. Thereafter, the New Health System shall furnish to the Commissioner a copy of any revisions to such policies immediately upon the effective date of such revisions. These policies shall 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. The New Health System shall 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 and on the separate web sites for all provider components that are part of the New Health System.*

9. *In order to ensure low income patients are not adversely affected due to pricing, uninsured or underinsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that Section governing not for-profit organizations, and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible.*

   "Uninsured" patients are those with no level of insurance or third-party assistance to assist with meeting his/her 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. These patients will not be charged more than amounts generally billed (AGB) to individuals who have insurance covering such care in case of Emergency or other Medically Necessary Services." AGB percentage is 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). Financial assistance eligibility 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. Financial assistance determinations are based on National Poverty Guidelines for the applicable

year. The New Health System shall adhere to the IRS regulatory guidelines set forth in Section 501(r) of the Internal Revenue Code.

How these two commitments would prevent the potential disadvantage: The adoption of a charity care policy will help ensure that low income patients continue to receive access to high-quality care. Since the new charity care policy will be similar to the existing policies of both parties, low income patients will continue to have access, along the same terms, towards needed care and services. The implementation of the charity care policy will aid in the New Health System's goal towards expanding the availability and access of care, while also ensuring that low income patients do not have to expend financial hardships to obtain access to care. These commitments shall be actively supervised through annual reports to the Commission that include data on the number of individuals receiving uncompensated care.

(D) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement.

Background: Some may argue that partial integration through a joint venture creates benefits in a less restrictive manner than a merger that poses competition concerns. It is true that partial integration preserves competition between parties outside the joint venture, but it also typically generates substantially smaller efficiency and quality benefits than a full merger. Under a Cooperative Agreement, structures are in place to ensure that the merger's benefits continue to outweigh the disadvantages resulting from the loss competition.

Assessment: The potential efficiencies and benefits identified in this Application could not be achieved without the merger and granting of a Cooperative Agreement. Moreover, the Parties' commitments relating to pricing, consolidation of services, and standardization of practices and procedures would raise significant antitrust concerns if undertaken together by two independent hospital systems. Alternatives that opponents may consider less restrictive to competition, but produce fewer benefits and several disadvantages than a Cooperative Agreement, are discussed below:

Status Quo. The two systems could continue to compete with each other, which is the status quo. However, in a Geographic Service Area that has one of the lowest Medicare Wage Indices in the country, negligible population growth and contains fourteen Health Professional Shortage Areas,[5] the status quo has produced a combined debt service of $1.5 billion, bond ratings below A grade (just above "junk" status) , and significant restrictions on the availability of capital to invest in the upkeep of existing infrastructure. With a continued decline in the rate of hospital admissions per capita, the status quo alternative is likely to result in significant reductions in staff, services, and rural facilities to maintain operating margins. While maintaining the status quo may be less restrictive to competition, it would not result in any of the benefits that would be made possible by the merger if the Cooperative Agreement is granted. In fact, maintaining the status quo is likely to result in significant disadvantages for the communities and the health of the region.

Joint Ventures: Most of the efficiencies identified by the New Health System could not be undertaken under Joint Venture arrangements. Because integration would be partial, not full,

[5] See http://www.hrsa.gov/shortage/mua/index.html.

meaningful reduction in unnecessary duplication, and the cost-savings and other associated benefits of the merger, would be sharply limited. To the extent there is integration, the Parties would need to share proprietary information, requiring the setting up of complex firewalls and other protections to protect against spillover of competitively sensitive information into areas outside the joint venture. In the past, the Parties have attempted to collaborate with respect to quality improvement methodologies and related projects, but these efforts have been unsuccessful due to the restrictive competitive environment. Specifically, the Parties, as competitors, have been unable to share proprietary information and have lacked a common clinical information system. A joint venture would eliminate the incentive for the Parties to move towards a Common Clinical IT Platform due to the significant investments both Parties have made towards their individual IT systems. Commitments relating to pricing, consolidation of services, standardization of practices, and procedures, would also raise significant antitrust concerns if undertaken together by two independent hospital systems in a joint venture arrangement. In addition, the Authority would have far less (if any) input in any joint venture arrangements between the Parties. The Parties have exhausted their viable joint venture options in the current competitive market. As a result, the Cooperative Agreement is needed for the Parties to realize the benefits made possible by the merger.

Out-of-Market Merger. Finally, the Parties wish to address the alternative of a merger by either Party with an out-of-market health system. While such a merger with a third- party is not a current alternative, it has been raised by opponents as less restrictive to competition than the merger between Wellmont and Mountain States.

The impetus behind the proposed merger of Wellmont and Mountain States was the independent decision of the Wellmont Board of Directors that Wellmont must merge with another system or be acquired in order to be successful long-term. This decision led to the search for a strategic-partner. The Board of Directors of Mountain States subsequently recognized that if Wellmont merged with an out-of-market entity, Mountain States would need to do the same in order to stay competitive against a better capitalized competitor.

If Wellmont and Mountain States are not allowed to merge under the Cooperative Agreement, both systems would continue their independent searches for partners outside the region. A merger by either Party with an out-of-market system would not require a Cooperative Agreement and would likely not trigger the same antitrust scrutiny. In this case, there is a reasonable concern that a merger by either Party with an out-of-market system could result in price increases for consumers since the out-of-market partner would be free to leverage any bargaining position without Commonwealth supervision.[6]

Other serious disadvantages could result from the merger by either Party with an out-of- market system. Specifically, local governance over health care operations would likely be lost. Well-paying jobs in the region may decrease as corporate business functions would be eliminated locally and centralized out-of-market. Any efficiencies gained from an out-of-market merger would likely be sent out of the region to two new corporate parents instead of being reinvested in public health, behavioral health, and academics and research as the Parties have committed to under the Cooperative Agreement. Finally, a merger with an out-of-market system by either Party

[6] See, e.g., Dafny, L., Ho, K., and Lee, R.S. "The Price Effects of Cross-Market Hospital Mergers." Working Paper, 2015 for discussion of these issues.

would likely result in the potential loss of access to health care in rural areas. As described in the Application, providing services in rural areas is often unprofitable, and it would be very difficult to maintain rural health care services in the long term without the commitments made by the two Parties under the Cooperative Agreement. In short, while a merger by either Party with an out-of-network system may be viewed as a less restrictive alternative to the merger of Wellmont and Mountain States, none of the benefits or efficiencies described in the Application would be likely to result from such an out-of-market merger. In fact, the unsupervised merger of either Party with an out-of-market system is likely to result in far more disadvantages for consumers and the community than a merger of Wellmont and Mountain States that is actively supervised by the Commonwealth.

Recommendation: The many benefits of the merger between Wellmont and Mountain States that are articulated in the Application and in the Parties commitments would not be possible without the non-labor, labor, and clinical efficiencies available as a result of the combination of local resources owned by Wellmont and Mountain States. Since the proposed consolidation of local assets would likely implicate Commonwealth and federal antitrust laws without a Cooperative Agreement, there is no less restrictive arrangement that would result in the same, or even similar, benefits. The Parties have already exhausted their joint venture opportunities in the current competitive environment. Maintaining the status quo or pursuing a combination with an out-of-market system is likely to result in far more disadvantages to consumers and the region than an actively-Commonwealth-supervised merger. As a result, there are no arrangements available that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the merger of Wellmont and Mountain States.

The Cooperative Agreement provides a unique mechanism for Wellmont and Mountain States to merge under active Commonwealth supervision. This structure allows the Commonwealth 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 Commonwealth ensures that the benefits of the merger will continue to outweigh any potential disadvantages and that the Commonwealth's policies underlying the granting of the Cooperative Agreement are fulfilled.