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P. O. Box 72050, Richmond, VA 23255-2050
T 804.967.9604 • F 804.967.9888
www.hdjn.com

January 20, 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 # 4

Dear Mr. Bodin,

Response # 4 to the questions received from your office on December 22, 2016, has been uploaded to the Citrix ShareFile platform.

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 # 4:

Section V. Additional Questions

L. Mental Health, Addiction Recovery and Substance Abuse
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O. The Virginia Facilities
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Q. Regional Exchange of Health Information and Information Systems
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R. Charity Policies
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Updates to previously submitted responses have also been uploaded for the following questions:

G. Governance
   1

M. Pricing
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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

851907.1

RESPONSE #4

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 20, 2017

V.G.1. Amended

G. Governance

1. The applicants state that the proposed system will be "locally governed." What is meant by "local"? How will it be ensured that the health concerns of local communities expressed demographically or by the communication of local leaders continue to be addressed after the merger and that local governance is maintained?

JOINT AMENDED RESPONSE: The Parties amend their response to question G-1, which was provided to the Commissioner on January 10, 2017, and provide **Amended Exhibit G-1A**. There are two changes made to **Exhibit G-1A**:

- Revised Commitment 1, made in consultation with the Authority and listed on **Exhibit G-1A**, sets forth the New Health System's commitment regarding a rate cap for payers, which states in part: "For all Principal Payers, the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System." Revised Commitment 1 includes a definition of Principal Payers. However, the definition of Principal Payers contained in the original **Exhibit G-1A** failed to include clarifying language that all Medicare Advantage plans, Medicaid managed care plans, and TriCare plans will be considered as Principal Payers for purposes of the rate cap and pricing commitments.

  The correct, complete definition of "Principal Payers" for purposes of the Application, including the Applicants' Revised Commitments, is as follows, with the new language highlighted here:

  > 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. In addition to the aforementioned Principal Payers, all Medicare Advantage plans, Medicaid managed care plans, and TriCare plans will be considered as Principal Payers for purposes of the rate cap and pricing commitments. 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 (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.

The full text of Revised Commitment 1 (including the revised definition of Principal Payers), which is contained in **Amended Exhibit G-1A**, now reads as follows:

1. **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[22], the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System. 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.[23]

[22] 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. In addition to the aforementioned Principal Payers, all Medicare Advantage plans, Medicaid managed care plans, and TriCare plans will be considered as Principal Payers for purposes of the rate cap and pricing commitments. 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 (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.

[23] For purposes of these commitments, the Commissioner shall not appoint an individual as his or her delegate if such person has a conflict of interest. If the Commissioner appoints an entity as his or her delegate, such as the Southwest Virginia Healthcare Authority, the entity must take steps to assure that no person involved with the entity in its role as the Commissioner's delegate has a conflict of interest. Notwithstanding anything herein to the contrary, the Commissioner shall retain the final authority with respect to conclusions reached by the Commonwealth or actions to be taken by the Commonwealth.

Timing: First full fiscal year following the first contract year after the formation 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.[24]

- Revised Commitment 9, made in consultation with the Authority and listed on **Exhibit G-1A**, sets forth the New Health System's commitment regarding its charity care policies and states in part: "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." However, the Parties have increased the amount to **two hundred twenty-five (225%)** of the federal poverty level to enhance this benefit for the region and the significant numbers of low income patients in Southwest Virginia.

  Amended Exhibit G-1A is provided to reflect this increase and the enhancement of our Commitment regarding the New Health System's charity care policies. All references in these Responses to **Exhibit G-1A** and to the Revised Commitments shall be deemed to be references to **Amended Exhibit G-1A** and to the amended Revised Commitments contained in **Amended Exhibit G-1A**.

  The full text of Revised Commitment 9, which is contained in **Amended Exhibit G-1A**, now reads as follows, with the change highlighted here:

  9. Commitment: 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 twenty-five percent (225%) 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.

     Timing: Immediately upon closing of the merger and ongoing.

     Amount: Extent of additional cost is unknown but is not immaterial.

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

Metric: Charity care costs as measured in cost of care furnished. For hospital services that number can come from the Medicare cost report S-10 schedule. New Health System's annual report to the Commissioner shall also include data on the number of individuals receiving uncompensated care and compare that number to prior fiscal years when the New Health System was in operation. The cost for charity care for nonhospital services may be estimated using the cost to charge ratio aggregated for all nonhospital services.

INDEX OF DOCUMENTS:

- Exhibit G-1A Amended New Health System Revised Commitments

V.L.2.

2. Please describe the merged leadership structure for these programs and its location.

JOINT RESPONSE: Behavioral Health Services at the New Health System will be organized under a service-line management structure similar to other service-lines such as Oncology and Cardiovascular Services. The service-line structure allows for services to be managed and directed locally under the direction of CEOs responsible for a geographic market. The service-line leader is responsible for working with each market to determine local needs in order to provide a coordinated regional response to those needs and may be supported in each market by additional service line staff. Although the exact service line structure for the New Health System has not yet been determined, service-line leaders may serve the entire system operating out of any geographic location.

Even with the New Health System's large investment, it is not expected that all the substance use disorder behavioral health needs of the region will be met. For this reason, in Virginia the New Health System plans to work closely with the Community Service Boards to determine where gaps exist in care and where to prioritize services in the region's communities. The New Health System expects that its investments will leverage existing capacity and infrastructure to expand existing services in the region beyond their current reach and to provide critical missing services. It is expected that the service-line leader will work closely with the local Community Services Boards in Virginia and other existing organizations with whom the New Health System plans to explore development of new services and expansion of current services.

V.M.20. Amended

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 AMENDED RESPONSE: The Applicants amend their response to Question M-20 submitted previously on 1/17/17 to submit the following revised definition of "Principal Payers." The definition previously submitted failed to include clarifying language that all Medicare Advantage plans, Medicaid managed care plans, and TriCare plans will be considered as Principal Payers for purposes of the rate cap and pricing commitments. The following is the complete, correct definition of "Principal Payers" (with the new language highlighted in yellow) for purposes of the Application, including the Applicants' Commitments, and we have restated the entire Response M-20 to include this new definition.

> 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. In addition to the aforementioned Principal Payers, all Medicare Advantage plans, Medicaid managed care plans, and TriCare plans will be considered as Principal Payers for purposes of the rate cap and pricing commitments. 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 (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.

RESTATED RESPONSE TO V.M-20 dated January 20, 2017

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: [60]

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[61], the New Health System will reduce existing commercial contracting for

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

[61] 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. In addition to the aforementioned Principal Payers, all Medicare Advantage plans, Medicaid managed care plans, and TriCare plans will be considered as Principal Payers for purposes of the rate cap and pricing commitments. 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 (COPA) do not occur as a result of increased market

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.[62]

1. **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.

   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

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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.

[62] 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.

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.

2. **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.

3. **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.2.

2. If there is any intention to remove or consolidate any services over the five (5) year forecast period at any Virginia facility, please detail and justify these intentions.

JOINT RESPONSE: The NHS intends to remove or consolidate certain redundant services – it would otherwise be impossible to achieve the synergies that fund the commitments to invest in public health, behavioral health, and research and academics. We do not currently have consolidation plans in place and cannot develop detailed plans prior to approvals and closing. As mentioned earlier, antitrust constraints will not permit the level of information and strategy exchange needed for the two legacy health systems to derive such plans without pure hypothesis as to what is in the best interest of the community. For decisions that would render a major service line or facility unavailable in a community, the NHS will use the process set forth in the Alignment Policy (Application Exhibit 12.1).

There are no current plans to close facilities. We have committed to keep all current WHS and MSHA hospitals open for five years as health care institutions.[72] During this period, all facilities will be thoroughly evaluated and assessed to ensure the best alignment of services across the spectrum of population need. We fully expect that evaluation to reveal inefficient models of care delivery that are not as supportive of high-quality care as they should be. In addition, we will uncover unmet community needs that should be addressed. While retaining current strengths, we have the opportunity to effectively repurpose facilities to better meet the comprehensive needs of the region.

Importantly, five of the seven WHS and MSHA hospitals in Southwest Virginia lose millions of dollars each year and are under-utilized as acute care hospitals. As financial pressures increase for the currently profitable parts of the health system that underwrite these losses, the viability of these hospitals under the status quo is in question. The merger provides a mechanism to derive overall system savings which can be reinvested to sustain and build health care resources in Southwest Virginia.

Wise County has three duplicating acute care hospitals, two in Norton and one in Big Stone Gap (about 11.5 miles away from Norton), each operating at a low average daily census.[73] There is a great opportunity to create a more cohesive spectrum and continuum of prevention, primary care, acute care, and post-acute care where all of the facilities relate to and support one another for the good of the community rather than simply inefficiently replicating one another. As stated above, all hospitals currently operating in Southwest Virginia will remain operational as health care facilities for at least five years post-merger. The essential services for communities where either MSHA or

[72] See Revised Commitment 20, **Exhibit G-1A**.

[73] As noted in Application Tables 5.2 and 5.3, Lonesome Pine has an average daily census of 10 (with a 17.4% licensed bed occupancy); Mountain View Regional has an average daily census of 13 (with a 16.9% licensed bed occupancy); and Norton Community has an average daily census of 35 (with a 27.3% licensed bed occupancy). Application pages 18-19.

WHS currently operate hospitals, including Wise County, are listed in Revised Commitment 20 (see **Exhibit G-1A**) should any currently operating hospitals be repurposed after that time.

V.O.9.

9. Is there a model of services or operations (e.g., fee for service, enrolled population, capitation, etc.), that will be offered at the different NHS Virginia facilities? Describe for each Virginia facility.

JOINT RESPONSE:

As described in a response to Tennessee Department of Health, New Health System (NHS) is committed to pursuing a transition to value-based approach to health care delivery that includes enhanced pay-for-value and risk-based models of population health medicine. The essential pathways include greater alignment of both incentives and operations under a single physician-led council and overall leadership to use the resources available in most effective way to address needs, improve outcomes, provide for greater financial stability and sustainability of care, and lead the way to greater ability for enhanced risk-based approaches. This may also include the development of a clinically integrated network in partnership with the independent physician community. Under these risk-based, value-based payment models and other initiatives, NHS will be incentivized for achieving cost and outcomes of care, and have incentives to keep the population. This commitment encompasses all NHS facilities and is not subject to individual facilities, stateliness, or regions.

I. Background

Successful navigation to risk-based models has proven challenging for many providers. Even though there is a vision for a new world order where providers take on more accountability and share more risk with payers, there is little consistency in the paths that either payers or providers are pursuing. As a result, experts have noted that there is a complex and narrow corridor to success.[77]

In the case of NHS, there are also unique challenges and barriers to success. The rural Appalachia region we serve is beset with poor health, low income levels, a declining and aging population, and the ongoing effects of economic decline.[78] Both Wellmont's and Mountain States' inpatient, emergency room, diagnostics, and pharmaceutical use rates are high by national standards and will be declining rapidly over the next ten years, creating a mandate for change in the traditional approach to health care delivery. The current infrastructure of Mountain States and Wellmont was built during a time of increasing utilization, much better economic conditions, and was designed for a fee-for-service model. Movement to a risk-based model requires significant investment in clinical and financial data systems, data analytics, care management processes and expertise, transparent close partnership relationships with the payers/employers, substantial capital resources, all connected by a well-developed vision and strategy. Health systems in regions of population growth are able to offset this decline in utilization and maintain the necessary revenues to fund these

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

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

While both systems could continue to explore value-based models and assume more risk independently over time, neither system currently has the capital, resources, appropriate distribution of primary care practitioners and specialists, ambulatory network, or right infrastructure to successfully accomplish a comprehensive transition without a dramatic shift of emphasis and strategy. Since most risk-based models are structured around primary care practitioners (PCPs) neither system has a broad enough primary care network, geographically or numerically, to manage the critical mass of covered lives necessary to go "at risk" with our five largest payers. This critical mass of covered lives is required for spreading actuarial and utilization risk.[79] Therefore, a clinically aligned network must be developed which includes both employed and independent physicians who share financial and clinical incentives.

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

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

Part of the rationale for the merger of Wellmont and Mountain States is that neither health system independently has the available resources to make these investments up front or access to a population large enough to merit the transition. The opportunity to make this transition with the

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

resources and population needed for success is specific to the merger and is based on the clinical integration that can be achieved through Ballad Health. While an out-of-market merger would increase scale, it would not result in clinical integration that inherently requires proximity of resources and shared patient experiences.

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

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

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

Wellmont and Mountain States each have experience with value-based models, including the formation of Accountable Care Organizations under the Medicare Shared Savings Program. In addition, both are participants in the current CMS Oncology Care Model, a highly competitive national model for care management of cancer patients. Mountain States participates in a shared savings arrangement for TennCare with AmeriGroup through its Integrated Solutions Health Network subsidiary. Both systems are fully participating in the "Episodes of Care" program that TennCare is rolling out over a five year period that started on January 1, 2015. Beyond this, the two health systems participate in scores of other value-based arrangements with various payers. The top five value-based programs for each system (ranked by population served) are summarized in **Exhibit V.O-9A** (Mountain States) and **Exhibit V.0-9B** (Wellmont) and submitted separately as confidential and proprietary information.

III. Strategy for Move to Risk-Based Models

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

Achieving financial flexibility and access to capital

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

Accessing expertise in development of risk-based models

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

Making up-front investments in needed infrastructure and personnel

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

Developing a cohesive clinically integrated network spanning the continuum of care

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

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

NHS will work with community partners to develop a robust Accountable Care Community, focused significantly on prevention and health education, and will resource its work to achieve long-term community health improvement goals in support of overall population health strategies.[80]

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

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

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

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

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

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

NHS will position itself for sophisticated risk arrangements by working with payers to achieve shared goals across their populations. While some diversity in individual payer population goals is expected, too much variation will result in disparate or under-resourced efforts which are not conducive to the assumption of greater levels of population risk. Alignment of goals and objectives across the regional population will allow NHS to make greater investments and assume higher levels of risk. This focus will include alignment of goals within similar commercial populations, similar Medicaid populations, and similar Medicare populations as these categories of patients have distinct health characteristics.[81]

Aligning incentives for performance and outcomes under risk-based models

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

IV. Addressing Variation Between Payer Populations

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

A. Public Sector (Medicare/Medicaid) Strategy

High-need, high-cost patients are concentrated principally in the Medicare and Medicaid populations.[82] In the elderly Medicare population, the high-need, high-cost patient profile often includes those beneficiaries with multiple chronic conditions, or those who are nearing the end of life.[83] Among Medicaid populations, mental illness or social determinants, such as homelessness, are drivers of persistently high spending patterns. While programs like the Medicare Shared Savings Program offer promising approaches and resources for Medicare Fee-for-Service populations, it is often challenging to extend these expanded services to Fee-For-Service patients. Similar dynamics exist on the Medicaid side. As a result, patients with similar clinical profiles in the very same practice may not be able to access the same level of care management services.

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[81] *See* Section IV, *infra*.

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

[83] *Id.*

One strategy for dealing with this is to align goals within certain patient categories. Research has shown that aligned patient intervention programs operate most efficiently when all the patients with complex conditions are eligible to participate in the program, regardless of payer.[84] This leads not only to better population health outcomes, but ultimately drives down the cost of care. By aligning multiple payers, NHS can coordinate quality measurement and reporting requirements in a way that amplifies incentives to undertake certain performance improvement activities. These incentives can then be used to invest in the infrastructure needed for complex care management.

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

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

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

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

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

Leveraging healthcare data analytics, innovative reimbursement structures, and patient-centric outreach will be important elements of strategy for NHS to successfully move private sector patients to value-based care. The implementation of the Common Clinical IT Platform will allow providers across the region to access patient records in an efficient manner. Aggregation of

[84] *Id.*

patient data at the system level will allow Ballad Health to pursue sophisticated data analytics programs that can drive quality initiatives and improved outcomes.

On the cost side, NHS will explore bundled payments and reimbursement for episodes of care that include financial incentives for providers. These initiatives will be especially important in areas like orthopedics and oncology where significant savings can be achieved through coordination of care and reduction of variation. The Physician Clinical Council will play an important role in implementing best practices across the system to achieve higher quality outcomes and reducing clinical variations which should yield significant savings.[85] NHS will also invest in cost-effective and accessible care options, like urgent care centers and telehealth, that allow patients to access care in a timely and affordable manner.

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

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

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

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

- 2017- 2018
    - Separate Mountain States and Wellmont charge masters are replaced by a NHS charge master that includes all inpatient and outpatient services.
    - Separate Mountain States and Wellmont managed care contracts are replaced by NHS managed care contracts with all Principal Payers. The NHS managed care contracts with the Principal Payers are expected to include value-based and risk-based model components. For the risk-based model components, NHS plans to establish go-live dates as follows:
        - All risk-based model components of existing Mountain States and Wellmont contracts would continue from the date of closing into the future.

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

- One new risk-based model contract would commence on January 1, 2019.
- One new risk-based model contract would commence on January 1, 2021.
- NHS would initiate risk-based model contracts for any remaining Principal Payers that do not already have at least one risk-based model component in their contracts no later than January 1, 2022.

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

- 2017-2019
  - Separate Mountain States and Wellmont contracts are replaced by NHS managed care contracts for all non-Principal Payers. The NHS managed care contracts with non-Principal Payers may include value-based components and may include elements of risk if connected to the broader shared goals of the Principal Payers.
  - No later than October 1, 2019, all of managed care contracts for NHS have been completed with all payers.

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

VI. The Structure and Infrastructure Needed for the Future

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

A. Health Information Systems

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

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

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

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

- It will support access to health information across the community for NHS providers as well as independent providers, medical groups and facilities.
- It will encourage and support patient and provider connectivity to integrated information system.
- It will provide key data security and relevant protocols to all users.
- It will further facilitate better patient care, coordination of care, and decrease the unnecessary duplication of health care services.

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

B. Financial and Clinical Analytic Systems

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

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

NHS will need to track the unit and case cost for all services for which it will be at risk under a value-based contract to ensure that costs are managed while quality and outcome targets are pursued. As a result, the availability and accuracy of this financial information will be critical to

the transformation or the merged entity. Not only will NHS need to track its own cost of care, but it will also need to determine the care costs of partners that will be sharing risk. Strong relationships with outpatient providers will be particularly important to for capturing and accessing data on outpatient costs.

C. Quality Information Systems

As a first step in the transition toward population health management, NHS will seek to expand contracts that offer patient satisfaction and care quality bonuses. Incentivizing patient satisfaction will encourage providers to engage patients in their care, and engaged patients tend to be healthier and less costly at the population level.[86] Incentivizing quality may reduce costs by increasing adherence to evidence-based care protocols that lead to improved outcomes.[87]

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

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

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

D. Care Management and Coordination Functions

Care coordination systems will be critical to the efficiencies needed for successful risk-based contracting. Case management software is important to support the workflow of case

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

managers, provide actionable care management plans at the point of service, and to provide the data for analysis of risk and care plan adherence and efficacy. The Clinical Council has been charged with developing the uniform guidelines, protocols, and outcome measures that will be implemented across the system. Data from multiple locations and providers, both employed and independent, will be collected and synthesized into comprehensive care plans, allowing providers to understand an individual patient's goals. At the same time, personnel in the NHS Department of Population Health will be measuring population-level goals that affect all patients.

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

E. Clinically Integrated Provider Network

Effective population health management requires continuous integration of clinical services across providers, care settings, and medical conditions—but not necessarily under single ownership.[88] Roughly 70% of the physicians in the Geographic Service Area are independent, and NHS is committed to developing structures that align clinical services with these groups as the population health and risk-based contracting efforts grow.

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

F. Accountable Care Community Support Systems

Finally, in furtherance of its population health management and risk-based contracting goals, NHS will need to invest significant resources in the systems needed to support the Accountable Care Community. These systems and resources are more fully described in the response to question V.F-5 to Virginia Department of Health request for additional information dated December 22, 2016.

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

V.Q.11.

11. Please detail the five (5) year consolidation plan for information systems transition to information systems in NHS from MSHA and WHS.

JOINT RESPONSE: Encompassed in any population health management strategy is the requirement for supporting information technology and analytics.[104] 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. The importance of information systems in this process supports the Parties' commitment to invest up to $150 million over ten years to ensure a Common Clinical IT Platform and interoperability among the New Health System's hospitals, physicians, and related services. **Exhibit Q-2C** contains a description of Ballad Health's IT integration strategy and the comprehensive plan for its significant investment in information technology, which will enable it to transform from traditional fee-for-service to value-based population health. As described in **Exhibit Q-2C**, 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.

The Parties have made several Commitments to the Southwest Virginia Health Authority regarding the New Health System's information systems.

Common Clinical IT Platform.

Timing: As soon as reasonably practicable after the formation of the New Health System, but no later than forty eight (48) months after formation, the New Health System will implement a Common Clinical IT Platform to enhance hospital quality, improve cost-efficiency, improve the utilization of hospital-related services, and to enhance opportunities in research.

Details: The New Health System will make access to the Common Clinical 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, hospital, 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. Implementation of the Common Clinical IT Platform will include mileposts that will be developed and proposed by the New Health System within three (3) months after closing, or

[104] 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.

by June 30, 2017, whichever is later. During the implementation period of the Common Clinical IT Platform, the New Health System will provide annual reports to the Commissioner attesting to the progress toward compliance with the Common Clinical IT Platform Commitment until the Common Clinical IT Platform is adopted. Following implementation, the New Health System will report in its annual report to the Commissioner any material enhancements or changes to the Common Clinical IT Platform and identify the researchers who have entered into Business Associate Agreements for purposes of conducting research.

Supervision: The Commissioner will be able to monitor implementation of promised system components based on the mileposts. The New Health System will report in each annual report to the Commissioner 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 the researchers (by individual or by group for those working together) who have entered into Business Associate Agreements for purposes of conducting research.[105]

Health Information Exchange

Timing: No later than thirty six (36) months after closing the New Health System will participate meaningfully in a health information exchange or cooperative arrangement.

Details: The health information exchange will allow privacy protected health information to be shared with community-based providers for the purpose of providing seamless patient care, to improve quality for patients, ensure seamless access to needed patient information, and to support efforts of the local physician community to access needed information to provide high quality patient care. The New Health System will invest up to $6 million over 10 years in furtherance of this commitment.

Supervision: The New Health System will report annually to the Commissioner on mileposts toward meeting this commitment.[106]

Quality Reporting

Timing: Annually, based upon when the New Health System establishes its annual quality goals.

Details: The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers. The reporting will enhance quality of patient care through greater transparency, improve utilization of hospital resources, and ensure the population health of the region is consistent with goals established by the Authority. The reporting will include posting of quality measures and actual performance on the New

[105] See Revised Commitment 19, **Exhibit G-1A**.
[106] See Revised Commitment 5, **Exhibit G-1A**.

Health System's website accessible to the public. The New Health System will report the 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 website 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.

Supervision: The Commissioner will have the ability to provide input into the priorities and reporting and can easily monitor the New Health System's quality reporting. The New Health System's annual report to the Commissioner will attest to measurement of quality measures identified in Section 15.a.A(iv) of the Cooperative Agreement Application. The Authority will be provided with notice of the priority metrics.[107]

[107] See Revised Commitment 8, **Exhibit G-1A**.

V.Q.17.

17. Please indicate what quality reporting systems are utilized by each Applicant.

a. Provide copies of all standard annual and monthly quality reports produced during the two (2) year historical baseline period for each Virginia facility, hospital and service. Provide examples of all special user generated reports from these that are routinely used by the Applicant in the normal course of business.

b. Provide a copy of the quality reports that were periodically provided to the Board of Trustees of each Applicant's during the two (2) year hospital baseline period.

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibit Q-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 Q-17A MSHA Quality Reporting – **PROPRIETARY**

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibit Q-17B** 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-17B WHS Quality Reporting – **PROPRIETARY**

V.R.1.

R. Charity Policies

1. **Large multi-hospital systems in Virginia typically provide sliding scale reductions for individuals and formulize between 200% and 450% of the Federal poverty level. Please provide a detailed analysis of the cost of doing this for Virginia and Tennessee facilities in the NHS.**

JOINT RESPONSE: Because household income information is not retained in our systems, we cannot effectively model the cost of implementing a sliding scale between 200% and 450% of the poverty level. However, the following narrative response reflects Ballad Health's approach to the provision of charity care and discounts for self-pay.

In order to ensure low income patients who are uninsured or under-insured are not adversely impacted due to pricing, Ballad Health has committed to adopt a charity care policy that is substantially similar to the existing policies of both Parties and consistent with the Internal Revenue Service's final 501(r) rule. For patients who qualify, Ballad Health will provide for the full write-off of amounts owed for services by patients with incomes at or below two hundred twenty-five percent (225%) of the federal poverty level.[109] For patients who do not qualify for full write offs, Ballad Health will discount services in compliance with rule 501(r) according to the ability of individuals and families to pay and will communicate discounts according to policy prior to service delivery or at the point of service to avoid creating any barrier to essential care. The write-off amount reflects a new commitment that we agreed to adopt as a result of discussions with the Southwest Virginia Health Authority. This commitment represents a higher level of charity care than Wellmont and Mountain States collectively offer now.

Practices will include payment plans that are manageable for patients and their families according to their individual circumstances. Ballad Health will work to connect people to insurance coverage and state and federal programs for which they qualify. Ballad Health will inform the public of its charity care and discounting policies in accordance with all applicable laws and shall post such policies on its publicly accessible web site. The activities related to charity care will occur immediately upon closing of the merger and will remain in place as long as the Cooperative Agreement remains in effect.

Ballad Health will also commit that neither Uninsured Patients nor Underinsured Patients will be charged more than amounts generally billed ("AGB") to individuals who have insurance covering such care in case of Emergency Services or other Medically Necessary Services. Financial assistance eligibility for patients of Ballad Health will be determined by a review of the Application for Financial Assistance, documents to support the Application for Financial Assistance (i.e. income verification

[109] This is an increase over the amount set forth in revised Commitment 9 made in consultation with the Authority and listed on **Exhibit G-1A**, previously provided to the Commissioner on January 10, 2017 in Response #1. The amount set forth in original revised Commitment 9 (and shown on **Exhibit G-1A**) established a level at or below 200% of the federal poverty level, but the Parties have increased the amount to 225% of the federal poverty level to enhance this benefit for the region and the significant numbers of low income patients in Southwest Virginia. An amended **Exhibit G-1A** is provided to reflect this increase and the enhancement of our Commitment regarding the New Health System's charity care policies.

documentation), and verification of assets. Ballad Health's financial assistance determinations will be based on National Poverty Guidelines for the applicable year. Ballad Health will adhere to the IRS regulatory guidelines set forth in Section 501(r) of the Internal Revenue Code.

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

V.S.3.

3. Provide all minutes of the Compensation Committee of each WHS and MSHA facility's board over the five (5) year historical baseline period.

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibit S-3A** 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-3A MSHA Compensation Committee Minutes Five Years – **PROPRIETARY**

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibit S-3B** 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-3B WHS Compensation Committee Minutes - **PROPRIETARY**

V.T.11.

11. Detail the proposed methodology to cap negotiated rates, including whether contractual out-of-pocket payments will be included.

JOINT RESPONSE: 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. As described in the revised commitments, for all Principal Payers, the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System.

- 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. In addition to the aforementioned Principal Payers, all Medicare Advantage plans, Medicaid managed care plans, and TriCare plans will be considered as Principal Payers for purposes of the rate cap and pricing commitments. 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 (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.
- 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.

Further, 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.

This rate cap 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 will 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.

For example, if the current multi-year managed care contract between WHS or MSHA and the managed care network included an automatic annual Inflator of 4% and Medical CPI was 3%, the NHS's rate cap would then reduce that inflator to 2.75% (25 basis points less than Medical CPI). This provision will automatically apply to all current contracts that remain in force as well.

The Parties anticipate that the cap on negotiated rates will be of substantial benefit to payers, employers, and consumers. With high-deductible health plans growing in popularity, and with the consumer bearing more of the financial responsibility for the cost of their care, the consumer's out-of-pocket payments will benefit from the use of these rate caps.

It should be noted that payers and employers determine all of the health plan designs, which result in how much out-of-pocket costs the consumers ultimately bear. The NHS has no role or control over the establishment of how much the out-of-pocket costs are and will not even know what an individual patient's financial responsibility is until the service has been delivered and the claim has been adjudicated by the payer. With a high-deductible plan, the patient may owe essentially all of the contracted rate for services early in their plan year, but may owe nothing for the same services later in their plan year once the patient has already met their annual high deductible.

As high-deductible plans have become increasingly common, both Parties have seen an increase in the percentage of payments paid by individual patients versus payers. This trend has negatively impacted collection rates for both Parties, which in turn has led to increases in charity care and bad debt. The NHS has no control over the amount owed by individual patients under each individual health plan and, by law, is prohibited from waiving the co-pays and deductible amounts an individual may owe based on their plan design.

V.T.19. Amended

1. Provide the current status regarding Fitch's Rating Watch for MSHA

AMENDED RESPONSE: MSHA provided a response to T-19 on January 10, 2017 and included MSHA's Audited Financial Statement as of June 30, 2015 (**Exhibit T-19**). However, the January 10, 2017 response unintentionally omitted a cross reference for the requested 2016 audited financial statements. Please see the following Exhibits, where the June 30, 2016 audited financial statements for MSHA and WHS are provided:

- Exhibit A-4A MSHA FY16 Audited Financial Statements
- Exhibit A-4B WHS FY16 Audited Financial Statements

V.T.31.

31. Do the price cap agreements apply to value-based or population-health contracts NHS signs with insurers?

JOINT RESPONSE: The price cap agreements apply to any and all fixed inflators as detailed in revised Commitments #1 and #2. (See **Exhibit G-1A**.) The price cap agreements do apply to all fixed inflators contained within all value-based or population health contracts.

As a threshold matter, "risk-based" contracting models exist on a spectrum of terms and conditions. The characterization "risk-based" can apply in many ways, depending on the contract. Some contracts have provisions for only upside risk to the provider (i.e., the potential for shared savings). Other contracts encompass upside and downside risk (i.e., the potential for the provider to have to pay money back for failure to achieve savings). For any current or foreseeable risk-based contract of which the Parties are aware, fee-for-service rates will apply to the services that are provided, i.e. to the particular episode of care from provider to patient. The rate Commitments made by the Parties would readily apply to such contracts, and will form a firm basis for transition to other future models of risk-based contracts.

LIST OF EXHIBITS FOR RESPONSE #4

SECTION V

Exhibit Number	**Description**
G-1A (amended)	Amended Joint NHS Revised Commitments
Q-17A	MSHA Quality Reporting ***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-3A	MSHA Compensation Committee Minutes Five Years ***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).**

Exhibit A-4B

WHS FY16 Audited Financial Statements

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Financial Statements

June 30, 2016 and 2015

(With Independent Auditors' Report Thereon)

WELLMONT HEALTH SYSTEM AND AFFILIATES

Table of Contents

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

Independent Auditors' Report

The Board of Directors
Wellmont Health System:

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Wellmont Health System and affiliates, which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Wellmont Health System and affiliates as of June 30, 2016 and 2015, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Nashville, Tennessee
October 26, 2016

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Balance Sheets

June 30, 2016 and 2015

(Dollars in thousands)

Assets		2016	2015
Current assets:			
Cash and cash equivalents	$	89,665	48,866
Assets limited as to use, required for current liabilities		4,022	3,651
Patient accounts receivable, less allowance for uncollectible accounts of approximately $46,132 and $33,297 in 2016 and 2015, respectively		96,106	112,299
Other receivables		10,899	11,238
Inventories		16,232	19,981
Prepaid expenses and other current assets		9,101	9,979
Total current assets		226,025	206,014
Assets limited as to use, net of current portion		423,144	424,864
Land, buildings, and equipment, net		458,545	484,569
Other assets:			
Long-term investments		24,423	27,964
Investments in affiliates		7,188	7,214
Deferred debt expense, net		3,934	4,217
Goodwill		51,399	51,583
Other		547	525
		87,491	91,503
Total assets	$	1,195,205	1,206,950
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	17,988	18,626
Accounts payable and accrued expenses		100,395	101,871
Estimated third-party payor settlements		12,696	12,987
Current portion of other long-term liabilities		5,025	7,660
Total current liabilities		136,104	141,144
Long-term debt, less current portion		462,240	480,187
Other long-term liabilities, less current portion		42,826	39,097
Total liabilities		641,170	660,428
Net assets:			
Unrestricted		543,327	535,632
Temporarily restricted		6,326	6,960
Permanently restricted		1,323	1,323
Total net assets attributable to Wellmont		550,976	543,915
Noncontrolling interests		3,059	2,607
Total net assets		554,035	546,522
Commitments and contingencies			
Total liabilities and net assets	$	1,195,205	1,206,950

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2016 and 2015

(Dollars in thousands)

	2016	2015
Revenue:		
Patient service revenue	$ 853,608	838,277
Provision for bad debts	(46,492)	(47,307)
Net patient revenue less provision for bad debts	807,116	790,970
Other revenues	19,844	21,759
Total revenue	826,960	812,729
Expenses:		
Salaries and benefits	404,172	399,955
Medical supplies and drugs	169,829	168,678
Purchased services	84,673	75,749
Interest	17,052	17,757
Depreciation and amortization	57,276	58,569
Maintenance and utilities	36,848	39,764
Lease and rental	16,032	15,435
Other	28,442	30,128
Total expenses	814,324	806,035
Income from operations	12,636	6,694
Nonoperating gains (losses):		
Investment income	5,288	14,207
Derivative valuation adjustments	82	(563)
Loss on refinancing	—	(1,389)
Nonoperating gains, net	5,370	12,255
Revenue and gains in excess of expenses and losses before discontinued operations	18,006	18,949
Discontinued operations	—	(2,720)
Revenue and gains in excess of expenses and losses	18,006	16,229
Income attributable to noncontrolling interests	(840)	(866)
Revenues and gains in excess of expenses and losses attributable to Wellmont	17,166	15,363
Other changes in unrestricted net assets:		
Change in net unrealized gains (losses) on investments	(8,764)	(18,555)
Net assets released from restrictions for additions to land, buildings, and equipment	4,511	2,712
Change in the funded status of benefit plans	(5,218)	(2,495)
Increase (decrease) in unrestricted net assets	7,695	(2,975)
Changes in temporarily restricted net assets:		
Contributions	4,895	2,545
Net assets released from temporary restrictions	(5,529)	(3,799)
Decrease in temporarily restricted net assets	(634)	(1,254)
Changes in permanently restricted net assets – investment income	—	4
Changes in noncontrolling interests:		
Income attributable to noncontrolling interests	840	866
Distributions to noncontrolling interests	(388)	(949)
Change in noncontrolling interests	452	(83)
Change in net assets	7,513	(4,308)
Net assets, beginning of year	546,522	550,830
Net assets, end of year	$ 554,035	546,522

See accompanying notes to consolidated financial statements.

WELLMONT HEALTH SYSTEM AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended June 30, 2016 and 2015

(Dollars in thousands)

	2016	2015
Cash flows from operating activities:		
Change in net assets	$ 7,513	(4,308)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	57,276	58,569
Loss (gain) on disposal of land, buildings, and equipment	401	(569)
Equity in earnings of affiliated organizations	(271)	(405)
Distributions from affiliated organizations	227	231
Amortization of deferred financing costs and premium, net	18	534
Net realized and unrealized loss (gain) on investments	14,804	18,182
Provision for bad debts	46,492	47,307
Change in fair value of derivative instruments	(82)	1,637
Loss on refinancing	—	1,389
Loss on impairment	—	66
Changes in assets and liabilities:		
Patient accounts receivable	(30,299)	(42,341)
Other current assets	4,627	(939)
Other assets	317	3,442
Accounts payable and accrued expenses	(2,022)	6,240
Estimated third-party payor settlements	(291)	4,562
Other current liabilities	(2,635)	(10,550)
Other liabilities	3,811	(6,925)
Net cash provided by operating activities	99,886	76,122
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	123,270	100,324
Purchase of investments	(133,114)	(101,791)
Purchase of land, buildings, and equipment	(31,096)	(39,044)
Proceeds from the sale of buildings and equipment	203	2,424
Net cash used in investing activities	(40,737)	(38,087)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	266	21,335
Payments on long-term debt	(18,616)	(40,746)
Payment of debt issuance costs	—	(432)
Net cash used in financing activities	(18,350)	(19,843)
Net increase in cash and cash equivalents	40,799	18,192
Cash and cash equivalents, beginning of year	48,866	30,674
Cash and cash equivalents, end of year	$ 89,665	48,866
Supplemental disclosures of noncash items:		
Wellmont entered into capital lease obligations for buildings and equipment in the amount of $30 and $8,284 in 2016 and 2015, respectively.		
Additions to property and equipment financed through current liabilities of $546 and $5,084 in 2016 and 2015, respectively.		

See accompanying notes to consolidated financial statements.

(1) Operations and Basis of Presentation

Wellmont Health System (Wellmont), a Tennessee not-for-profit corporation, currently operates six acute care hospitals in Tennessee and Virginia that include Bristol Regional Medical Center in Bristol, Tennessee, Holston Valley Medical Center in Kingsport, Tennessee, Lonesome Pine Hospital in Big Stone Gap, Virginia, Hawkins County Memorial Hospital in Rogersville, Tennessee, Hancock County Hospital in Sneedville, Tennessee, and Mountain View Regional Medical Center in Norton, Virginia.

The consolidated financial statements also include the operations of:

- Wellmont Cardiology Services and Wellmont Medical Associates, which operate physician practices.
- Wellmont Madison House and Wellmont Wexford House, which operate assisted living, adult day care, and skilled nursing facilities.
- Wellmont Foundation, which conducts fund-raising activities for the benefit of Wellmont.
- Wellmont Integrated Network, LLC, which is an accountable care organization.
- Wellmont Insurance Company SPC, Ltd, which is a captive insurance company.
- Wellmont, Inc., a wholly owned taxable subsidiary of Wellmont, formed as the holding company of various other taxable subsidiaries that provide medical collection services, provide other healthcare-related services, and invest in affiliates and other activities.

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

Wellmont's continuing operations consist primarily of the delivery of healthcare services in northeast Tennessee and southwest Virginia.

(2) Significant Accounting Policies

A summary of significant accounting policies is as follows:

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Significant estimates include allowances for contractual adjustments and bad debts; third-party payor settlements; valuation of investments, land, buildings, equipment, and goodwill; and self-insurance and other liabilities. Actual results could differ from these estimates.

(b) Cash and Cash Equivalents

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

(c) Investments

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

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

(d) Assets Limited as to Use

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

(e) Inventories

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

(f) Land, Buildings, and Equipment

Land, buildings, and equipment are stated at cost, if purchased, or fair value at date of donation. Depreciation is computed using the straight-line method based on the estimated useful life of the asset, ranging from 3 to 40 years. Buildings and equipment held under capital leases are recorded at net present value of future lease payments and are amortized on a straight-line basis over the shorter of the lease term or estimated useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Upon sale or retirement of land, buildings, or equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss, if any, is included in other revenues on the consolidated statements of operations and changes in net assets. Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

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

(g) Goodwill

Wellmont follows ASU No. 2010-07, *Not for Profit Entities: Mergers and Acquisitions*, which in part requires healthcare entities to follow Accounting Standards Codification (ASC) Topic 350-20-35, *Intangibles – Goodwill and Other along with ASU 2011-08, Testing Goodwill for Impairment*. ASC Topic 350-20-35 requires goodwill of not-for-profit entities to be evaluated for impairment at least annually. An entity has the option to first assess qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If, after assessing the totality of events or circumstances, an entity determines it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. The more-likely than-not threshold is defined as having a likelihood of more than 50%. However, if an entity concludes otherwise, then it is required to perform the first step of the two-step impairment test by calculating the fair value of the reporting unit and comparing the fair value with the carrying amount (including goodwill) of the reporting unit. If the carrying amount of a reporting unit exceeds its fair value, then the entity is required to perform the second step of the goodwill impairment test to measure the amount of the impairment loss. Under step two, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation and the residual fair value after this allocation is the implied fair value of the reporting unit goodwill. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, step

two does not need to be performed. The annual impairment test is performed as of June 30. During fiscal year 2016 and 2015, there were no impairment losses recorded.

(h) Deferred Debt Expense

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

(i) Derivative Financial Instruments

As further described in note 13, Wellmont is a party to interest rate swap and other derivative agreements. These financial instruments are not designated as hedges and are presented at estimated fair market value in the accompanying consolidated balance sheets. These fair values are based on the estimated amount Wellmont would receive, or be required to pay, to enter into equivalent agreements with a third party at the valuation date. Due to the nature of these financial instruments, such estimates are subject to significant change in the near term. Wellmont recognizes changes in the fair values of derivatives as nonoperating gains or losses in the consolidated statements of operations and changes in net assets. The cash settlements resulting from these interest rate swaps are reported as interest expense in the consolidated statements of operations and changes in net assets.

(j) Asset Retirement Obligations

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

(k) Temporarily and Permanently Restricted Net Assets

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

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

Net assets are released from restrictions by Wellmont incurring expenses that satisfy the restricted purposes. Such net assets released during 2016 and 2015 primarily included amounts related to the purchase of equipment for pediatrics, cancer, and other healthcare operations.

Wellmont has adopted guidance issued by Financial Accounting Standards Board (FASB), which provides guidance on the net asset classification of donor-restricted endowment funds for a tax-exempt organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA). Effective July 1, 2007, the State of Tennessee adopted legislation that incorporates the provisions outlined in UPMIFA. Wellmont's endowments consist solely of donor-restricted endowment funds. Wellmont's endowments consist of five individual funds established for a variety of purposes.

Wellmont has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, Wellmont classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are approved for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, Wellmont considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the organization and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the organization; and (7) the investment policies of the organization.

(l) Net Patient Service Revenue and Accounts Receivable

Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by patients and various third-party payors under provisions of reimbursement formulas in effect, including retroactive adjustments under reimbursement agreements. Estimated retroactive adjustments are accrued in the period related services are rendered and adjusted in future periods as final and other settlements are determined. On the basis of historical experience, a significant portion of Wellmont's uninsured patients will be unable or unwilling to pay for the services provided. Therefore, Wellmont records a significant provision for bad debts related to uninsured patients in the period the services are provided. This provision for bad debts is presented on the statements of operations as a component of net patient revenue. Wellmont provides care to patients who meet criteria under its charity care policy without charge or at amounts less than its established rates. Because Wellmont does not pursue collection of amounts determined to qualify as charity care, they are not included in net patient service revenue.

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

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

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

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

(n) Contributed Resources

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

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

(Dollars in thousands)

(o) Federal Income Taxes

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

(p) Recently Adopted Accounting Standards

In May 2015, the FASB issued ASU No. 2015-07, *Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share (or Its Equivalent)*. This ASU removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. The amendments also remove the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. Rather, those disclosures are limited to investments for which the entity has elected to measure the fair value using the practical expedient. Wellmont early implemented the provisions of ASU 2015-07 during fiscal year 2015.

(3) Goodwill

A summary of goodwill for the years ended June 30 is as follows:

	2015	Additions	Decreases	2016
Goodwill	$ 51,583	—	(184)	51,399

	2014	Additions	Decreases	2015
Goodwill	$ 51,649	—	(66)	51,583

(Dollars in thousands)

(4) Net Patient Service Revenue

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the consolidated statements of operations and changes in net assets is as follows for the years ended June 30:

		2016	2015
Gross patient service revenue	$	3,015,757	2,973,219
Less:			
Contractual adjustments and other discounts		(2,079,156)	(2,069,377)
Charity care		(82,993)	(65,565)
Net patient service revenue before provision for bad debts		853,608	838,277
Less provision for bad debts		(46,492)	(47,307)
Net patient service revenue	$	807,116	790,970

Wellmont's allowance for doubtful accounts is predominantly for self-pay patients and patient balances remaining after third-party payments. The provision for bad debts decreased $815 from fiscal 2015 to fiscal 2016 and the net write-offs decreased $41,331 from fiscal 2015 to fiscal 2016. The decrease in write-offs was due to the implementation of a new billing system in the last quarter of fiscal 2014, which then caused a catch up on write-offs in fiscal 2015. During fiscal 2016 patient service balances returned to a normal level. Wellmont has not changed its charity care or uninsured discount policies during fiscal 2016. Wellmont does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(5) Third-Party Reimbursement Arrangements

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

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

(Dollars in thousands)

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

Net patient service revenue in 2016 and 2015 related to Medicare and TennCare/Medicaid and net patient accounts receivable at June 30, 2016 and 2015 from Medicare and TennCare/Medicaid were as follows:

		2016	2015
Net patient service revenue:			
Medicare	$	351,319	337,813
TennCare/Medicaid		54,709	49,883
Net patient accounts receivable:			
Medicare	$	38,754	33,101
TennCare/Medicaid		5,804	6,474

Wellmont has filed cost reports with Medicare and Medicaid. The cost reports are subject to final settlement after audits by the fiscal intermediary. The Medicare and Medicaid cost reports have been audited and final settled by the intermediary through June 30, 2011 and audit adjustments have been received and considered for certain hospitals and year-ends through June 30, 2014.

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

Net patient service revenue is reported at the net amounts billed to patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Estimated retroactive adjustments are accrued in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Net patient service revenue increased approximately $238 and $2,735 in 2016 and 2015, respectively, due to final settlements and revised estimates in excess of amounts previously recorded, removal of allowances previously estimated that are no longer necessary as a result of audits and final settlements, and years that are no longer subject to audits, reviews, and investigations.

Estimated settlements recorded at June 30, 2016 could differ materially from actual settlements based on the results of third-party audits.

(Continued)

(6) Meaningful Use Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record (EHR) technology. The Medicare incentive payments are paid out to qualifying hospitals and physician groups over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals, and physician groups must meet EHR "meaningful use" criteria that become more stringent over three stages as determined by Centers for Medicare & Medicaid Services (CMS). Medicaid programs and payment schedules vary from state to state.

For fiscal years ended June 30, 2016 and 2015, Wellmont recorded $203 and $3,233, respectively, in other operating revenue related to the EHR and meaningful use incentives. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria.

Amounts recognized represent management's best estimates for payments ultimately expected to be received based on estimated discharges, charity care, and other input data. Subsequent changes to these estimates will be recognized in other operating revenue in the period in which additional information is available. Such estimates are subject to audit by the federal government or its designee.

(7) Charity Care and Community Services

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

Wellmont maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone and estimated costs incurred for services and supplies furnished under its charity care policy. Costs incurred are estimated based on the ratio of total operating expenses to gross charges applied to charity care charges. Charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services, and the equivalent percentage of charity care patients to all patients serviced were $82,993 and $21,717, and 3.0%, respectively, for the year ended June 30, 2016 and $65,565 and $17,254, and 2.7%, respectively, for the year ended June 30, 2015.

In addition to the charity care services described above, Wellmont provides a number of other services to benefit the indigent for which little or no payment is received. Medicare, Medicaid, and state indigent programs do not cover the full cost of those services. The shortfall between actual receipts from those programs and Wellmont's cost of providing care to those patients totaled $30,731 and $37,818 for the years ended June 30, 2016 and 2015, respectively.

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

(Dollars in thousands)

(8) Investment in Affiliates

Wellmont has investments with other healthcare providers, which include home care, regional laboratories, and other healthcare-related organizations. Wellmont records its share of equity in the operations of the respective organizations. Equity in earnings of affiliates was approximately $271 and $405 for the years ended June 30, 2016 and 2015, respectively, and is included in other operating revenue in the consolidated financial statements. Wellmont received distributions of $227 and $231 during 2016 and 2015, respectively, which reduced Wellmont's overall investment in the affiliates.

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

		2016	2015
Total assets	$	135,466	116,359
Total liabilities		35,357	28,284
Total net assets	$	100,109	88,075
Net revenues	$	149,947	150,253
Expenses		142,192	141,825
Revenues in excess of expenses	$	7,755	8,428

Wellmont's investment in these affiliates and its ownership percentage as of June 30, 2016 and 2015 is as follows:

		Amount		Percentages	
		2016	2015	2016	2015
Advanced Home Care	$	6,092	6,092	6%	6%
Others		1,096	1,122	15%–50%	15%–50%
	$	7,188	7,214		

(Continued)

(Dollars in thousands)

(9) Investments

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

		2016	2015
Assets limited as to use by Board for capital improvements:			
Stock mutual funds	$	166,232	155,165
Bond mutual funds		148,783	157,091
Cash and money market funds		7,050	9,530
Real estate funds		17,560	17,967
Alternative investments (private equity, hedge funds, commingled funds, and real estate funds):			
Liquid		14,092	14,911
Illiquid		26,992	28,012
		380,709	382,676
Assets limited as to use under self-insurance agreements:			
Cash and money market funds		16,449	16,992
Assets limited as to use under bond indenture agreements:			
Cash and money market funds		30,008	28,847
Less assets limited as to use that are required for current liabilities		4,022	3,651
Assets limited as to use, net of current portion	$	423,144	424,864
Long-term investments:			
Stock mutual funds	$	15,033	15,627
Bond mutual funds		8,142	9,535
Right of first refusal		—	1,512
Cash, money market funds, and certificates of deposit		19	242
Real estate funds		1,229	1,048
Total long-term investments	$	24,423	27,964

Investments in certain alternative limited partnership investments contain agreements whereby Wellmont is committed to contribute approximately $13,594 as of June 30, 2016 of additional funds to the limited partnerships in the form of capital calls at the discretion of the general partner, of which $1,339 was paid subsequent to June 30, 2016.

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

(Continued)

(Dollars in thousands)

Wellmont evaluates whether unrealized losses on investment securities indicate other-than-temporary impairment. Based on this evaluation, Wellmont recognized other-than-temporary impairment losses of $2,404 and $845 on investments as of June 30, 2016 and 2015, respectively. Other-than-temporary impairment losses are considered as realized losses and are reported within "investment income" in the consolidated statements of operations and changes in net assets.

Gross unrealized losses on investments for which other-than-temporary impairments have not been recognized and the fair values of those investments, aggregated by the length of time that individual investments have been in a continuous unrealized loss position, at June 30, 2016 and 2015 were as follows:

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2016:						
Alternative investments	$ 187	3,186	313	1,419	500	4,605
Mutual funds	1,591	39,954	6,682	119,671	8,273	159,625
	$ 1,778	43,140	6,995	121,090	8,773	164,230

	Less than 12 months		12 months or more		Total	
	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value
2015:						
Alternative investments	$ 396	2,975	12	459	408	3,434
Mutual funds	3,282	128,081	8,508	72,699	11,790	200,780
	$ 3,678	131,056	8,520	73,158	12,198	204,214

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

	2016	2015
Interest and dividends, net of amounts capitalized	$ 11,250	13,677
Realized (losses) gains on investments, net	(5,962)	530
Investment income, net	$ 5,288	14,207
Change in net unrealized gains (losses) on investments	$ (8,764)	(18,555)

(Continued)

(Dollars in thousands)

(10) Land, Buildings, and Equipment

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

	2016	2015
Land	$ 49,763	49,536
Buildings and improvements	536,411	530,904
Equipment	533,620	517,990
Buildings and equipment under capital lease obligations	54,131	54,316
	1,173,925	1,152,746
Less accumulated depreciation	(726,653)	(674,587)
	447,272	478,159
Construction in progress	11,273	6,410
Land, buildings, and equipment	$ 458,545	484,569

Depreciation and amortization expense for the years ended June 30, 2016 and 2015 was $57,276 and $58,569, respectively. Included is amortization related to capitalized software and equipment under capital leases. Accumulated amortization for equipment under capitalized software and lease obligations was $29,784 and $26,168 as of June 30, 2016 and 2015, respectively.

(11) Other Long-Term Liabilities

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

	2016	2015
Workers' compensation liability	$ 11,164	12,195
Professional and general liability	13,838	15,465
Postretirement benefit obligation	2,111	2,487
Asset retirement obligation	3,350	3,353
Pension benefit liability	16,260	12,020
Other	1,128	1,237
	47,851	46,757
Less current portion	(5,025)	(7,660)
Total other long-term liabilities	$ 42,826	39,097

(Continued)

(Dollars in thousands)

(12) Debt

(a) Long-Term Debt

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

	2016	2015
Hospital Refunding Bonds, Series 2014A	$ 9,937	12,137
Hospital Refunding Bonds, Series 2014B	46,835	49,615
Hospital Refunding Bonds, Series 2014C	16,836	18,836
Hospital Revenue Bonds, Series 2014D	13,575	13,575
Hospital Revenue Bonds, Series 2014E	21,335	21,335
Hospital Revenue Refunding Bonds, Series 2011	73,420	74,410
Hospital Revenue Bonds, Series 2007A	55,000	55,000
Hospital Revenue Refunding Bonds, Series 2006C	180,420	180,420
Project Odyssey 2012 Tax-Exempt Master Lease/Sublease Financing	27,977	34,341
Notes payable	9,569	9,771
Capital lease obligations	20,107	23,864
Other	281	308
	475,292	493,612
Unamortized premium	4,936	5,201
	480,228	498,813
Less current maturities	(17,988)	(18,626)
	$ 462,240	480,187

(b) Series 2014 Bonds

On June 25, 2014, Wellmont issued the Hospital Revenue Refunding Bonds, Series 2014A, Series 2014B, Series 2014C, and Series 2014D. The Series 2014A through Series 2014D Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. On September 1, 2014, the 2014E Bonds were issued by The Health, Educational, and Housing Facilities board of the County of Sullivan, Tennessee on behalf of Wellmont. All of the Series 2014 Bonds were issued as tax-exempt and were issued in accordance with the Amended and Restated Master Trust Indenture dated September 1, 2014.

(Continued)

The Series 2014 Bonds were issued with four maturities; Series 2014A for $14,242, maturing September, 1, 2019, Series 2014B for $52,275, maturing September 1, 2032, Series 2014C for $20,836, maturing September 1, 2024, Series 2014D for $13,575, maturing September 1, 2040, and Series 2014E for $21,335, maturing September 1, 2022. Principal and interest will be paid annually, except there will be interest only paid on the Series 2014D through September 2030 with principal payments beginning on September 1, 2031 and on the Series 2014E through September 2016 with principal payments beginning September 1, 2017.

Interest on the Series 2014 Bonds is 100% of LIBOR plus a quotient of applicable spread divided by 67%. Accrued interest is paid monthly in arrears. Interest rates on the 2014A, 2014B, 2014C, 2014D and 2014E Bonds were 1.07%, 1.17%, 1.15%. 1.15%, and 1.15%, respectively, as of June 30, 2016.

The Series 2014C and Series 2014D Bonds can be called by the bondholders June 1, 2021 and each successive year after that until they mature. The Series 2014E Bonds can be called by the bondholders September 1, 2021 and on June 1 each successive year after that until they mature.

(c) Project Odyssey 2012 Tax-Exempt Master Lease/Sublease Financing

On December 1, 2012, The Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee (as Lessee) and Wellmont (as Sub-Lessee) entered into a Master Equipment Lease and Sublease Agreement with Banc of America Public Capital Corp (the Lessor). The proceeds of this Master Lease were used to finance an electronic medical records system consisting of an EpicCare Inpatient Clinical System and an EpicCare Ambulatory Electronic Medical Records System inclusive of hardware, software, and implementation services. The Sub-Lessee authorized the Lessor to take a security interest in the entire System although only certain components of the System were funded under this Master Lease with the rest funded by Bank of America N.A. and Sub-Lessee. During the fiscal year ended June 30, 2014, Wellmont received two draws totaling $26,349. Each lease term shall commence and interest shall begin to accrue on the date any funds are advanced by Wellmont. The first six lease payments under each agreement consist only of an interest component and the remaining 78 lease payments consist of a principal component and an interest component. Commencing on June 30, 2013, and continuing on the first day of each fiscal quarter thereafter, Wellmont shall pay accrued interest on the outstanding balance of the loan. Each agreement will have an interest component based on a fixed rate of interest and payable with respect to the amount of funds that the Lessor has advanced. The rates of interest range from 1.45% to 1.97%.

(d) Series 2011 Bonds

On May 5, 2011, Wellmont refunded the Revenue Bonds, Series 2006A, with the proceeds of the Revenue Bonds, Series 2011. The Series 2011 Bonds were issued by Health, Educational, and Housing Facilities Board of the County of Sullivan, Tennessee on behalf of Wellmont. The Series 2011 Bonds were issued with two maturities of $42,385 and $33,780 for 2026 and 2032, respectively. The Series 2011 Bonds maturing September 1, 2026 are subject to mandatory redemption prior to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2013 and ending on September 1, 2026 in annual amounts ranging from $865 to $4,680. The Series 2011 Bonds maturing September 1, 2032 are subject to mandatory redemption prior

to maturity pursuant to the operation of a sinking fund, in part by lot starting on the redemption dates beginning on September 1, 2027 and ending on September 1, 2032 in annual amounts ranging from $4,980 to $6,300. The Series 2011 Bonds were issued as fixed-rate obligations at 6.0% and 6.5% for the two maturities (2026 and 2032, respectively).

(e) Series 2007 Bonds

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

Principal on outstanding Series 2007A Bonds is payable through maturity or mandatory sinking fund redemption in annual amounts ranging from $360 to $2,460 commencing on September 1, 2017 through September 1, 2036, with a balloon payment of $29,245 due on September 1, 2037. The outstanding bonds accrue interest at rates ranging from 5.125% to 5.250%.

(f) Series 2006 C

On October 26, 2006, The Health, Educational, and Housing Facilities Board of the County of Sullivan Tennessee issued, on behalf of Wellmont, $200,000 of Hospital Revenue Bonds, Series 2006C. The Series 2006C Bonds were used to finance the costs of acquisition of land for expansion, construction, expansion, equipping, and renovation of HVMC, including the construction of a new patient tower (collectively known as Project Platinum); finance the costs of the construction, expansion, equipping, and renovation of the emergency department at BRMC (the Bristol Emergency Department Project); and finance the costs of construction, expansion, renovation, and equipping of an operating room and related facilities at Hawkins County Memorial Hospital.

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

(g) Master Trust Indenture

The master trust indenture and loan agreements for the 2014, 2011, 2007, and 2006 bonds contain certain requirements regarding deposits to trustee funds, maintenance of rates, maintenance of debt service coverage and liquidity, permitted indebtedness, and permitted disposition of assets. Gross receipts of Wellmont collateralize the bonds. The purpose of the master trust indenture is to provide a mechanism for the efficient and economical issuance of notes by individual members of Wellmont using the collective borrowing capacity and credit rating of Wellmont. The master trust indenture requires individual members of Wellmont to make principal and interest payments on notes issued for their benefit. The master trust indenture also requires Wellmont members to make payments on notes issued by other members of Wellmont if such other members are unable to satisfy their obligations under the master trust indenture. Payments of principal and interest on certain bonds are also insured by bond insurance policies.

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

(h) Notes Payable

In August 2011, Wellmont entered into a note agreement in the amount of $1,760 with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate with a ceiling of 7.75% and a floor of 4.00% and a maturity date of August 2016. At June 30, 2016 and 2015, $64 and $446, respectively, were outstanding on this note.

On October 17, 2012, Wellmont entered into a 10-year $12,500 term note payable with Bank of America, N.A. The proceeds were used for the EpicCare system and its implementation, among other general corporate purposes. The note payable has a fixed interest rate of 3.27% and a maturity date of December 13, 2022. At June 30, 2016 and 2015, $9,254 and $9,254, respectively, were outstanding on this note.

On January 4, 2013, Wellmont entered into a three-year $193 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of December 2015. At June 30, 2016 and 2015, $0 and $45, respectively, were outstanding on this note.

On March 25, 2013, Wellmont entered into a three-year $47 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of August 2016. At June 30, 2016 and 2015, $5 and $26, respectively, were outstanding on this note.

On January 15, 2016, Wellmont entered into a 5-year $266 term note payable with a variable interest rate indexed to *The Wall Street Journal* U.S. Prime Rate and a maturity date of January 15, 2021. At June 30, 2016, $246 was outstanding on this note.

(Dollars in thousands)

(i) Capital Lease Obligations

Assets under capital leases are included in property and equipment and have a net carrying value of $24,347 and $28,148 as of June 30, 2016 and 2015, respectively. Amortization of capital assets is included in depreciation expense. The lease obligations are recorded at the net present value of the minimum lease payments with interest rates from 2.1% to 12.0%.

(j) Long-Term Debt Maturities Schedule

Bond maturities in accordance with the terms of the Master Trust Indenture and other long-term debt maturities for each of the next five years and in the aggregate at June 30, 2016 are as follows:

2017	$	17,988
2018		20,130
2019		20,097
2020		20,567
2021		37,462
Thereafter		359,048
	$	475,292

Interest paid for the years ended June 30, 2016 and 2015 was $16,545 and $19,881, respectively, net of amounts capitalized. Interest costs of $0 and $210 were capitalized in 2016 and 2015, respectively.

(13) Derivative Transactions

Wellmont is and has been a party to a number of interest rate swap agreements. Such swaps have not been designated as hedges and are valued at estimated fair value in the accompanying consolidated balance sheets. By using derivative financial instruments to hedge exposures to changes in interest rates, Wellmont exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes Wellmont, which creates credit risk for Wellmont. When the fair value of a derivative contract is negative, Wellmont owes the counterparty, and therefore, Wellmont is not exposed to the counterparty's credit risk in those circumstances. Pursuant to the terms of its interest rate swap agreements, Wellmont is required to postcollateral with its counterparties under certain specified conditions. Collateral posting requirements are based on the amount of Wellmont's derivative liability and Wellmont's bond rating. As of June 30, 2016 and 2015, Wellmont was not required to postcollateral related to its swaps.

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

(Dollars in thousands)

Management's primary objective in holding such derivatives is to introduce a fixed or variable rate component into its variable rate debt structure using LIBOR rates. The fair value as of June 30, 2016 and 2015 was approximately $172 and $90, respectively. The change in the fair value of the derivative instruments was approximately $82 and $1,637, respectively, in 2016 and 2015 and is included in nonoperating gains in the consolidated statements of operations. The terms of the swap agreements allow netting of all amounts due from/to the counterparty. Effective May 28, 2015, Wellmont terminated and settled three of the interest rate swaps resulting in a loss of $2,200 included in Nonoperating gains (losses) in the consolidated statements of operations and changes in net assets. The following is a summary of the interest rate swap information as of June 30, 2016:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset
Total return swap	Series 2011	$ 75,300	May 5, 2011	April 1, 2021	0.012%	0.063%	$ 172
							$ 172

The following is a summary of the interest rate swap information as of June 30, 2015:

Type of interest swap	Debt hedging	Notional amount	Effective date	Maturity date	Rate paid	Rate received	Swap fair value asset
Total return swap	Series 2011	$ 75,300	May 5, 2011	September 1, 2032	1.220%	6.249%	$ 90
							$ 90

(14) Pension and Other Postretirement Benefits

Wellmont sponsors a retirement program and defined-contribution retirement plan (Retirement Plan) that covers substantially all employees. Wellmont makes annual contributions to the Retirement Plan in an amount equal to 2% of each participant's base wages and contributes an additional amount, based on each participant's voluntary contributions, which cannot exceed certain limits established in the Internal Revenue Code, up to 2.4% of each participant's wages. The total pension expense related to the Retirement Plan was $7,518 and $8,841 for the years ended June 30, 2016 and 2015, respectively.

A predecessor to Wellmont sponsored a noncontributory, defined-benefit pension plan covering, substantially all its employees. However, effective June 30, 1996, this plan was frozen and no further benefits accrue. One of Wellmont's acquired hospitals also sponsored a defined-benefit pension plan covering substantially all its employees, but the two plans were merged on June 30, 2007 and effective June 30, 2010, the plan was frozen for all employees and no further benefits accrue.

(Dollars in thousands)

The defined-pension benefits are actuarially determined based on a formula taking into consideration an employee's compensation and years of service. The funding policy is to make annual contributions to the plan based upon the funding standard developed by the plan actuary. This standard uses the projected unit credit actuarial cost method, including the amortization of prior service costs, over a 20-year period. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. Wellmont recognizes the funded status (i.e., difference between the fair value of plan assets and projected benefit obligations) of its defined-benefit pension plans as an asset or liability in its consolidated balance sheet and recognizes changes in that funded status in the year in which the changes occur as a change in unrestricted net assets. The defined-benefit pension plans use a June 30 measurement date.

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

		2016	2015
Change in benefit obligation:			
Benefit obligation at beginning of year	$	55,080	56,291
Service cost		—	—
Interest cost		2,263	2,176
Actuarial loss(gain)		3,251	(886)
Benefits paid		(2,603)	(2,501)
Benefit obligation at end of year		57,991	55,080
Change in plan assets:			
Fair value of plan assets at beginning of year		43,060	45,250
Actual return on plan assets		(1,177)	(1,591)
Employer contribution		2,451	1,902
Benefits paid		(2,603)	(2,501)
Fair value of plan assets at end of year		41,731	43,060
Funded status	$	(16,260)	(12,020)
Amounts recognized in the accompanying consolidated balance sheets:			
Pension benefit liability (other long-term liabilities)	$	(16,260)	(12,020)

(Continued)

(Dollars in thousands)

		2016	2015
Amounts not yet reflected in net periodic benefit cost and included as an accumulated charge to unrestricted net assets:			
Unrecognized actuarial loss	$	23,924	18,901
Unrecognized prior service cost		—	—
Net amounts included as an accumulated charge to unrestricted net assets	$	23,924	18,901
Calculation of change in unrestricted net assets:			
Accumulated charge to unrestricted net assets, end of year	$	23,924	18,901
Reversal of accumulated charge to unrestricted net assets, prior year		(18,901)	(16,777)
Change in unrestricted net assets	$	5,023	2,124
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:			
Actuarial loss (gain) arising during the year	$	7,221	3,869
Amortization of actuarial loss		(2,198)	(1,745)
Amortization of prior service cost		—	—
Net amounts recognized in unrestricted net assets	$	5,023	2,124

(Continued)

(Dollars in thousands)

		2016	2015
Estimate of amounts that will be amortized from unrestricted net assets to net pension cost in 2017:			
Amortization of net loss	$	3,000	2,200
Amortization of prior service cost		—	—
Estimated future benefit payments:			
Fiscal 2016	$	—	2,882
Fiscal 2017		2,938	2,987
Fiscal 2018		3,047	3,079
Fiscal 2019		3,132	3,162
Fiscal 2020–2023		3,215	
Fiscal 2021–2025		20,211	20,295
Weighted average assumptions used to determine benefit obligations:			
Settlement (discount) rate		3.50%	4.25%
Weighted average rate of increase in future compensation levels		N/A	N/A
Components of net periodic benefit cost (benefit):			
Service cost	$	—	—
Interest cost		2,263	2,176
Expected return on plan assets		(2,793)	(3,164)
Amortization of net loss		2,198	1,745
Net periodic benefit cost	$	1,668	757
Weighted average assumptions used to determine net periodic benefit cost:			
Settlement (discount) rate		4.25%	4.00%
Expected long-term return on plan assets (HVMC)		6.50	7.00
Expected long-term return on plan assets (LPH)		6.50	7.00
Weighted average rate of increase in future compensation levels		N/A	N/A

Wellmont's overall expected long-term rate of return on assets is 6%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Wellmont has developed a plan investment policy, which is reviewed and approved by the board of directors. The policy established goals and objectives of the fund, asset allocations, asset classifications, and manager guidelines. The policy dictates a target asset allocation and an allowable range for such categories based on quarterly investment fluctuations. Investments are managed by independent advisers who are monitored by management and the board of directors.

(Continued)

(Dollars in thousands)

The table below shows the target allocation and actual asset allocations as of June 30, 2016 and 2015:

Asset	Target allocation	2016	2015
Equity securities	47%	47%	47%
Fixed income	41	38	33
Cash	—	7	3
Other	12	8	17

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

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

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

	Postretirement benefits	
	2016	2015
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 2,487	2,633
Interest cost	76	86
Plan participants contributions	15	16
Actuarial losses	(346)	(172)
Benefits paid	(121)	(76)
Benefit obligation at end of year	2,111	2,487
Change in plan assets:		
Fair value of plan assets at beginning of year	—	—
Employer contribution	106	60
Plan participants contributions	15	16
Benefits paid	(121)	(76)
Fair value of plan assets at end of year	—	—
Funded status	$ (2,111)	(2,487)

(Continued)

(Dollars in thousands)

	Postretirement benefits	
	2016	2015
Amounts recognized in the consolidated balance sheets consist of:		
Current liabilities	$ (152)	(179)
Noncurrent liabilities	(1,959)	(2,308)
Accumulated charge to unrestricted net assets	5,372	5,568
	$ 3,261	3,081

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

	2016	2015
Net actuarial gain	$ 5,372	5,568

Net periodic benefic cost recognized and other changes in plan assets and benefit obligations recognized in unrestricted net assets in 2016 and 2015 were as follows:

	Postretirement benefits	
	2016	2015
Net periodic benefit cost:		
Interest cost	$ 76	86
Amortization of net gain	(541)	(544)
Net periodic benefit recognized	(465)	(458)
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:		
Net actuarial loss	(346)	(173)
Amortization of net gain	541	544
Total recognized in unrestricted net assets	195	371
Total recognized in net periodic benefit cost and unrestricted net assets	$ (270)	(87)

(Continued)

(Dollars in thousands)

The net gain and prior service credit for the defined-benefit postretirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $(541) and $(544), respectively. Weighted average assumptions used to determine benefit obligations for 2016 and 2015 were as follows:

	2016	2015
Discount rate	3.00%	3.75%
Rate of compensation increase	—	—
Healthcare cost trend rate	4.50	5.00

Weighted average assumptions used to determine net benefit cost for 2016 and 2015 were as follows:

	Postretirement benefits	
	2016	2015
Discount rate	3.75%	3.50%
Expected long-term rate of return on plan assets	N/A	N/A
Rate of compensation increase	N/A	N/A
Healthcare cost trend rate	5.00	5.00

Wellmont's overall expected long-term rate of return on assets is 6%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

For measurement purposes, a 7.15% annual rate of increase in the per capita cost of covered healthcare benefits was assumed for 2016.

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

		2016	2015
Effect of one-percentage-point increase in healthcare cost trend on:			
Service and interest cost	$	3	5
Accumulated pension benefit obligation		102	143
Effect of one-percentage-point decrease in healthcare cost trend on:			
Service and interest cost	$	(3)	(5)
Accumulated pension benefit obligation		(90)	(124)

(Continued)

(Dollars in thousands)

The asset allocations of Wellmont's pension and postretirement benefits as of June 30, 2016 and 2015, respectively, were as follows:

	Fair value measurement at June 30, 2016 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 35,593	35,593	—	—
Cash and money market funds	2,675	2,675	—	—
Fixed income fund	2,340	—	2,340	—
	40,608	38,268	2,340	—
Alternative funds – recorded at net asset value	1,123			
Total	$ 41,731			

	Fair value measurement at June 30, 2015 pension benefits – plan assets			
	Total	**Quoted prices in active markets for identical assets (Level 1)**	**Significant other observable inputs (Level 2)**	**Significant unobservable inputs (Level 3)**
Assets:				
Stock mutual funds	$ 34,625	34,625	—	—
Cash and money market funds	1,121	1,121	—	—
Fixed income fund	3,721	—	3,721	—
	39,467	35,746	3,721	—
Alternative funds – recorded at net asset value	3,593			
Total	$ 43,060			

(Continued)

(Dollars in thousands)

The following assets have been estimated using net asset value per share of the investments as of June 30, 2016 and 2015.

	June 30		Redemption frequency	Redemption notice period
	2016	2015		
Hedge funds (a)	$ 726	2,610	90 days	90 days
Private equity investments (b)	397	603	Not eligible	Not eligible
Real estate partnerships (c)	—	380	Not eligible	Not eligible
	$ 1,123	3,593		

(a) Includes investment in fund structures that pursue multiple strategies to diversify risks and reduce volatility. The fair value of these investments is calculated from the net asset value of Wellmont's ownership interest in these funds. Fund managers have the ability to shift investments across a wide variety of sectors, geographies, and strategies and from a net long position to a net short position. Certain investments in hedged strategies may be subject to restrictions that limit Wellmont's ability to withdraw capital until i) a certain "lock-up period" has expired or ii) until certain underlying investments designated as "illiquid" in "sidepockets" are sold. In addition, this class includes investments that may be subject to restrictions that limit the amount that Wellmont is able to withdraw as of a given redemption date.

(b) Includes illiquid investments in venture capital, growth equity, buyout, mezzanine, distressed debt and reinsurance held in commingled vehicles in which Wellmont is typically a limited partner or shareholder. The fair value of these investments is calculated from the net asset value of Wellmont's ownership interest in these funds. The nature of the investments in this category is such that distributions are received through liquidation of the underlying assets of the funds at the underlying manager's discretion in accordance with the terms of each fund.

(c) Includes illiquid investments in real estate assets, projects or land held in commingled funds. The fair value of these investments is calculated from the net asset value of Wellmont's ownership interest in these funds. The nature of the investments in this category is such that distributions are received through liquidation of the underlying assets of the funds at the underlying manager's discretion in accordance with the terms of each fund.

(Continued)

(15) Self-Insurance Programs

Wellmont is self-insured for professional and general liability and workers' compensation liability. Consulting actuaries have been retained to determine funding requirements and estimate claim liability exposures. Wellmont Insurance Company SPC, Ltd (the captive) was formed in 2014 as a wholly owned captive insurance company in the Cayman Islands. The captive holds Wellmont's self-insurance liabilities for professional and general liability and is funded by transfers from Wellmont Health System. These funds are included in assets limited as to use.

The professional and general liability self-insurance program is supplemented by umbrella excess liability policies consisting of various layers of coverage with commercial carriers based on policy year. The workers' compensation program is supplemented for Tennessee and Virginia by excess workers' compensation policies, with a commercial carrier for statutory limits per occurrence. Provisions based on actuarial estimates are made for the ultimate cost of claims asserted, as well as estimates of claims incurred but not reported as of the respective consolidated balance sheet dates. Workers' compensation expense under these programs amounted to approximately $1,962 and $4,612 for the years ended June 30, 2016 and 2015, respectively, and are included in salaries and benefits expense in the accompanying consolidated statements of operations and changes in net assets. All other self-insurance expense under these programs amounted to approximately $852 and $1,568 for the years ended June 30, 2016 and 2015, respectively, and are included in other expense in the accompanying consolidated statements of operations and changes in net assets.

At June 30, 2016 and 2015, Wellmont was involved in litigation relating to medical malpractice, workers' compensation and other claims arising in the ordinary course of business. There are also known incidents that occurred through June 30, 2016 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Claims have been filed requesting damages in excess of the amount accrued for estimated malpractice costs. Management of Wellmont is of the opinion that estimated professional and general liability amounts accrued at June 30, 2016 are adequate to provide for potential losses resulting from pending or potential litigation. Amounts of claim settlements may be more or less than what has been provided for by management. The ultimate settlement of claims could be different from recorded accruals, with such differences being potentially significant.

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

(16) Commitments and Contingencies

Construction in progress at June 30, 2016 and 2015 relates primarily to the completion of certain buildings and renovations. Total costs to complete these and other projects were approximately $7,694 at June 30, 2016. Wellmont has entered into contracts of $7,694 related to these projects.

(Continued)

(Dollars in thousands)

Wellmont leases certain equipment and office space under operating lease agreements. Total rental expense under cancelable and noncancelable agreements was $16,032 and $15,453 for the years ended June 30, 2016 and 2015, respectively. Minimum future lease payments under noncancelable operating leases with initial or remaining lease terms in excess of one year as of June 30, 2016 are as follows:

2017	$ 9,065
2018	7,519
2019	6,454
2020	5,750
2021	3,781
2022	10,520
	$ 43,089

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

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

On July 1, 2014, Wellmont sold its 60% interest in Takoma Regional Hospital to Adventist Health System (which owned the remaining 40%). The sale agreement included a Put provision which is currently in dispute. Dependent on the resolution of that dispute, Wellmont may be required to purchase Takoma in fiscal year 2017 for approximately $19,500.

(Dollars in thousands)

(17) Functional Expense Disclosure

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

	2016	2015
Professional care of patients	$ 651,044	652,458
Administrative and general	162,250	152,549
Fund-raising	1,030	1,028
	$ 814,324	806,035

(18) Income Taxes

Wellmont, Inc. and its subsidiaries file consolidated federal and separate-company state income tax returns. These companies have combined net operating loss carryforwards for federal income tax purposes of approximately $111,000 at June 30, 2016, which begin expiring in fiscal 2019 and expire through 2033. These net operating losses can be used to offset future consolidated taxable income of Wellmont, Inc. and subsidiaries. Wellmont participates in certain activities that generate unrelated business taxable income. These activities have generated net operating losses in prior years, and Wellmont files a Form 990-T with the Internal Revenue Service to report such activity. Wellmont has net operating loss carryforwards for federal income tax purposes of approximately $1,735 for unrelated business activities. Management believes that it is more likely than not that deferred tax assets arising from net operating loss carryforwards will not be realizable. Accordingly, these are fully reserved at June 30, 2016 and 2015.

(19) Concentration of Credit Risk

Wellmont grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross accounts receivable from patients and third-party payors at June 30, 2016 and 2015 was as follows:

	2016	2015
Medicare	46%	43%
TennCare/Medicaid	10	12
Other third-party payors	29	32
Patients	15	13
	100%	100%

(Continued)

(20) Disclosures about Fair Value of Financial Instruments

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer or settle a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820, *Fair Value Measurements*, establishes a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The classification of an investment within the hierarchy is based upon the pricing transparency or ability to redeem the investment and does not necessarily correspond to the perceived risk of that investment. Inputs are used in applying various valuation techniques that are assumptions, which market participants use to make valuation decisions, including assumptions about risk. Inputs may include price information, volatility statistics, operating statistics, specific and broad credit data, liquidity statistics, recent transactions, earnings forecasts, future cash flows, market multiples, discount rates, and other factors. ASC Topic 820 permits, as a practical expedient, for the estimation of the fair value of investment in investment companies for which the investment does not have a readily determinable fair value using net asset value per share or its equivalent. Net asset value in many instance may not equal fair value that would be calculated pursuant to ASC Topic 820. In accordance with ASC Topic 820, investments measured using net asset value as a practical expedient are not categorized within the fair value hierarchy, however, the amount measured is included to permit reconciliation of the fair value of investments included in the fair value hierarchy to the line items presented in the consolidated statement of operations and changes in net assets.

Assets and liabilities measured and reported at fair value are classified within the fair value hierarchy as follows:

Level 1 – Valuations based on quoted market prices in active markets.

Level 2 – Investments that trade in markets that are considered to be active, but are based on dealer quotations or alternative pricing sources supported by observable inputs or investments that trade in markets that are not considered to be active, but are valued based on quoted market prices, dealer quotations, or alternative pricing sources supported by observable inputs.

Level 3 – Investments classified within Level 3 have significant unobservable inputs, as they trade infrequently or not at all.

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

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2016:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 89,665	—	—	89,665
Assets limited as to use:				
Stock mutual funds	166,232	—	—	166,232
Bond mutual funds	148,783	—	—	148,783
Cash and money market funds	53,507	—	—	53,507
Real estate funds	17,560	—	—	17,560
	475,747	—	—	475,747
Alternative investments – recorded at net asset vaue				41,084
Subtotal				516,831
Long-term investments:				
Stock mutual funds	15,033	—	—	15,033
Bond mutual funds	8,142	—	—	8,142
Cash and money market funds	19	—	—	19
Real estate funds	1,229	—	—	1,229
Subtotal	24,423	—	—	24,423
Derivative asset	—	172	—	172
Total	$ 500,170	172	—	541,426

(Continued)

(Dollars in thousands)

The following table presents assets and liabilities that are measured at fair value on recurring basis at June 30, 2015:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 48,866	—	—	48,866
Assets limited as to use:				
Stock mutual funds	155,165	—	—	155,165
Bond mutual funds	157,091	—	—	157,091
Cash and money market funds	55,369	—	—	55,369
Real estate funds	17,967	—	—	17,967
	434,458	—	—	434,458
Alternative investments – recorded at net asset vaue				42,923
Subtotal				477,381
Long-term investments:				
Stock mutual funds	15,627	—	—	15,627
Bond mutual funds	9,535	—	—	9,535
Cash and money market funds	242	—	—	242
Real estate funds	1,048	—	—	1,048
Subtotal	26,452	—	—	26,452
Derivative asset	—	90	—	90
Total	$ 460,910	90	—	503,923

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

- *Cash and Cash Equivalents*

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

- *Patient Accounts and Other Receivables*

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

- *Investments and Assets Limited as to Use*

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

(Continued)

(Dollars in thousands)

Alternative investments are not categorized within the fair value hierarchy because fair value is measured using the net asset (NAV) per share practical expedient. Wellmont's alternative investments' prices are obtained from the fund manager. For Wellmont's fund of funds, the manager receives account statements directly from independent administrators or the underlying hedge fund managers, who are responsible for the pricing of these funds. Before reliance on these valuations, the managers evaluate the investee fund's fair value estimation processes and control environment, the investee fund's policies and procedures for estimating fair value of underlying investments, the investee fund's use of independent third party valuation experts, the portion of the underlying securities traded on active markets, and the professional reputation and standing of the investee fund's auditor.

The following investments have been estimated using net asset value per share of the investments as of June 30, 2016 and 2015.

	June 30		Redemption frequency	Redemption notice period
	2016	2015		
Hedge funds (a)	$ 14,092	14,912	90 days	90 days
Private equity investments (b)	8,798	9,846	Not eligible	Not eligible
Real estate partnerships (c)	18,194	18,165	Not eligible	Not eligible
	$ 41,084	42,923		

(a) Includes investment in fund structures that pursue multiple strategies to diversify risks and reduce volatility. The fair value of these investments is calculated from the net asset value of Wellmont's ownership interest in these funds. Fund managers have the ability to shift investments across a wide variety of sectors, geographies, and strategies and from a net long position to a net short position. Certain investments in hedged strategies may be subject to restrictions that limit Wellmont's ability to withdraw capital until i) a certain "lock-up period" has expired or ii) until certain underlying investments designated as "illiquid" in "sidepockets" are sold. In addition, this class includes investments that may be subject to restrictions that limit the amount that Wellmont is able to withdraw as of a given redemption date. In May 2016, the Fund managers communicated that the funds will be liquidated, the capital will be returned to investors and the Funds dissolved. It is estimated that the underlying assets of the funds will be liquidated over the next 2 years.

(b) Includes illiquid investments in venture capital, growth equity, buyout, mezzanine, distressed debt and reinsurance held in commingled vehicles in which Wellmont is typically a limited partner or shareholder. The fair value of these investments is calculated from the net asset value of Wellmont's ownership interest in these funds. The nature of the investments in this category is such that distributions are received through liquidation of the underlying assets of the funds at the underlying manager's discretion in accordance with the terms of each fund.

(Continued)

(c) Includes illiquid investments in real estate assets, projects or land held in commingled funds. The fair value of these investments is calculated from the net asset value of Wellmont's ownership interest in these funds. The nature of the investments in this category is such that distributions are received through liquidation of the underlying assets of the funds at the underlying manager's discretion in accordance with the terms of each fund.

- *Accounts Payable and Accrued Expenses*

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

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

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

- *Long-Term Debt*

  The carrying amount of indebtedness with variable interest rates approximates its fair value because the variable rates reflect current market rates for indebtedness with similar maturities and credit quality. The fair value of indebtedness with fixed interest rates is based on rates assumed to be currently available for indebtedness with similar terms and average maturities. Fair value measurements of indebtedness are based on observable interest rates and maturity schedules that fall within Level 2 of the hierarchy of fair value inputs. The estimated fair value of revenue bonds, using current market rates, was estimated at $421,115 and $455,650 for the years ended June 30, 2016 and 2015, respectively. The carrying amount of other long-term debt reported in note 12 and on the consolidated balance sheet approximates the related fair value.

(21) Subsequent Events

Wellmont has evaluated subsequent events from the balance sheet date through October 26, 2016, the date at which the consolidated financial statements were issued. No material subsequent events were identified for recognition or disclosure.

Amended Exhibit V.G-1A
New Health System Revised Commitments

1. **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[1], the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System. 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.[2]

   Timing: First full fiscal year following the first contract year after the formation 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.[3]

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[1] 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. In addition to the aforementioned Principal Payers, all Medicare Advantage plans, Medicaid managed care plans, and TriCare will be considered as Principal Payers for purposes of the rate cap and pricing commitments 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 (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.

[2] For purposes of these commitments, the Commissioner shall not appoint an individual as his or her delegate if such person has a conflict of interest. If the Commissioner appoints an entity as his or her delegate, such as the Southwest Virginia Healthcare Authority, the entity must take steps to assure that no person involved with the entity in its role as the Commissioner's delegate has a conflict of interest. Notwithstanding anything herein to the contrary, the Commissioner shall retain the final authority with respect to conclusions reached by the Commonwealth or actions to be taken by the Commonwealth.

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

2. **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.

   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[4] 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.

[4] Nothing herein is intended to override dispute resolution provisions that may be parts of binding contracts between New Health System (in its own name or as a successor to the Applicants) and any payer.

Metric: Easily verifiable.

3. **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.

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 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.

Timing: No later than 36 months after closing.

Amount: Up to $6 million over 10 years.

Metric: The New Health System shall report annually to the Commissioner on mileposts toward meeting this commitment.

6. **Commitment:** 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.

   Timing: No later than 36 months after closing.

   Metric: The New Health System shall report to the Commissioner on the mileposts toward meeting this commitment.

7. **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.

8. **Commitment:** 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.

   Timing: Annually, based upon when the New Health System establishes its annual quality goals.

   Metric: Compliance with commitment as agreed upon and modified subsequently.

9. **Commitment:** 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 twenty-five percent (225%) 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.

   Timing: Immediately upon closing of the merger and ongoing.

   Amount: Extent of additional cost is unknown but is not immaterial.

   Metric: Charity care costs as measured in cost of care furnished. For hospital services that number can come from the Medicare cost report S-10 schedule. New Health System's annual report to the Commissioner shall also include data on the number of individuals receiving uncompensated care and compare that number to prior fiscal years when the New Health System was in operation. The cost for charity care for nonhospital services may be estimated using the cost to charge ratio aggregated for all nonhospital services.

10. **Commitment:** 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.

Timing: Immediately upon closing and ongoing.

Metric: Credible report.

11. **Commitment:** In order to demonstrate the New Health System maintains the financial viability to fulfill its commitments of this Cooperative Agreement, and to ensure proper state supervision, any notices of default, technical or otherwise, that the New Health System, or an affiliate, receives under bond or other debt documents, must be furnished to the Authority and the Commonwealth.

    Timing: Ongoing.

    Amount: No cost.

    Metric: Credible report.

12. **Commitment:** In order to demonstrate the New Health System maintains the financial viability to fulfill its commitments of this Cooperative Agreement, and to ensure proper state supervision, If the New Health System records a liability for a Material Adverse Event which may impair the ability of the New Health System to fulfill the commitments, the New Health System will notify the Authority within 30 days of making such a determination.

    Timing: Ongoing.

    Amount: No cost.

    Metric: Credible report and easy to determine.

13. **Commitment:** 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.

    Timing: First year.

    Metric: Easily verifiable.

14. **Commitment:** In order to ensure a uniform system of compensation, and to ensure competitiveness of pay for attracting and retaining employees, the New Health System will work as quickly as practicable after completion of the merger to invest up to $70 million over 10 years addressing differences in salary/pay rates and employee benefit structures between Wellmont and Mountain States. The New Health System will offer competitive compensation

and benefits for its employees to support its vision of becoming one of the strongest health systems in the country and one of the best health system employers in the country.

Timing: By the end of the first full fiscal year upon closing of the merger.

Amount: The estimated incremental investment in addressing salary/pay rate differences is approximately $70 million over 10 years.

Metric: Credible report which shall be provided confidentially in order to preserve a competitive employment environment. Such report will include if there were grievances filed by employees with respect to pay adjustments related to the merger and how the grievances were addressed.

15. **Commitment:** In order to ensure employees are treated fairly in the event there is a facility closure or termination of services related directly and demonstrably to the merger, the New Health System will provide to the Commissioner, within two (2) months of closing, a severance policy addressing how employees will be compensated if they are not retained by the New Health System or any of its subsidiaries or affiliates. This policy shall not affect termination of employees if the termination was for-cause or related to the routine operation of such facility. The severance policy shall consider several factors, including but not limited to, each individual's position within his/her current organization and years of service. The policy will also address outplacement support to be provided to any such employee. Compliance with this commitment in Virginia shall be judged solely by the Commissioner and corrective action required for noncompliance shall be determined solely by the Commissioner. This provision shall not be construed to create a right of action for any individual employee.

    Timing: 5 years.

    Amount: Severance cost is estimated to be approximately $5 million from the closing of the merger to the end of the first full fiscal year after the closing of the merger, attributable mostly to corporate level synergies. Severance cost thereafter is not easily calculable due to unknown variables in the market, including ongoing attrition in the workforce as inpatient hospital use rates continue to decline.

    Metric: Confidential annual report for the first five full fiscal years after the closing of the merger reporting on the total number of involuntary employee terminations due to merger-related reductions, the number of such terminations for which severance compensation was paid, and the aggregate cost of such severance compensation. Importantly, it is also recognized that there will be new employment created as the New Health System makes the committed investments in research, academics, new specialties and services and population health. The New Health System may also provide as part of the annual report the number of new jobs created due to such investments, and approximate incremental payroll costs resulting.

16. **Commitment:** In order to invest in the advancement of employees, and to assist employees in achieving growth in their careers, the New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

    Timing: No later than 24 months after closing.

Metric: Credible report.

17. **Commitment:** In order to ensure training of physicians and allied health professionals meets the goals and objectives of the health system and the Authority, the New Health System will develop, in partnership with at least its current academic partners, a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in Virginia and Tennessee. The plan will include, but not be limited to, how it will address the Authority's goals, how training will be deployed in Virginia and Tennessee based on the assessed needs, clinical capacity and availability of programs. Contingent on continued funding for existing programs from federal and state sources, the New Health System will not reduce or eliminate any medical residency programs or available resident positions presently operated by the Applicants at any Virginia facility provided, however, that such programs may be moved within Virginia, or substituted for residency training in Virginia in other specialties if that is in the best interests of the patient population in the area. Notwithstanding the foregoing, minor and temporary decreases in the number of full time equivalent residents working at Virginia hospitals may reflect year-to-year variations in residents applying for such training, dropping out of such training, electing to rotate to other hospitals, or transferring to another residency program, and shall not be deemed to violate this agreement.

    Timing: 10 years.

    Amount: Combination of commitments 17 and 18 total $85 million.

    Metric: Annually, the New Health System will report to the Commissioner: the number of accredited resident positions for each residency program operated in Virginia and the number of such positions that are filled, and shall furnish copies of the relevant pages of the Medicare cost reports showing the number of full time equivalent residents. An annual report shall also include a description of any affiliation agreements moving resident "slots" from one hospital to another pursuant to Medicare rules, resident programs moved from one hospital to another, and new programs started. No later than June 30, 2018, the New Health System will furnish to the Commissioner a plan for medical residency training programs and other health care professional training. The plan shall set forth the targeted number of persons to be trained by physician specialty or health care professional category, the location(s) of such training, the schedule for starting such training, and the expected gross annual expenditure relating to such training. It is acknowledged that the service area for the New Health System extends across state boundaries and patients, employees, and vendors freely cross those state lines. Accordingly, the Commissioner will not apply a fixed ratio to determine whether each year's expenditure under commitments number 17 and 18 is appropriately shared in by Virginia. On the other hand, the Commissioner will review expenditures made pursuant to this commitment for appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

18. **Commitment:** In order to help create opportunities for investment in research in partnership with Virginia's academic institutions, the New Health System is committed to collaborating with the academic institutions to compete for research opportunities. The New Health System will work closely with current academic partners to develop and implement a 10-year plan for

investment in research and growth in the research enterprise in Virginia and Tennessee service area. The plan will include, but not be limited to, how it will address the Authority's goals, how research will be deployed in Virginia and Tennessee based on the needs and opportunities, capacity and competitiveness of the proposals.

Timing: 10 years.

Amount: Combination of commitments 17 and 18 total $85 million.

Metric: Report in year one and dollars spent thereafter. The New Health System will present a plan for research expenditures for full fiscal years two and three starting after the closing of the merger no later than the end of the first fiscal year after the merger. Thereafter, the New Health System must update its plan to address subsequent fiscal years no later than the end of the period for which the prior plan ends up to the end of the ninth full fiscal year after the closing of the merger. The annual report should include a description of research topics, the entities engaged in the research, the principal researcher(s) who is/are responsible for each project, any grant money applied for or expected, and the anticipated expenditures. Annual reports for full fiscal years three and through ten should report on the outcome of previously reported research projects including references to any published results. The Commissioner will review expenditures made pursuant to this commitment for appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

19. **Commitment:** 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.

    Timing: Implementation No later than 48 months after closing.

    Amount: Up to $150 million.

    Metric: Implementation of promised system with mileposts along the way. The mileposts shall be proposed by New Health System 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 the researchers (by individual or by group for those working together) who have entered into Business Associate Agreements for purposes of conducting research.

20. **Commitment:** 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.

Timing: Ongoing.

Amount: The net cost varies depending on annual operating losses. The current annual operating losses for the predecessors of the New Health System for Virginia hospitals that are losing money are approximately $11 million.

Metric: Each year, the operating results for the Virginia hospitals and sites furnishing "essential services" as defined above will be reported to the Commissioner. 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.

21. **Commitment:** 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.

    Timing: Immediately upon closing of the merger and ongoing.

Amount: Not applicable.

Metric: Easily verifiable. 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.

22. **Commitment:** 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.

    Timing: Immediate upon closing of the merger and ongoing, subject to current contractual obligations.

    Amount: No cost.

    Metric: Easily verifiable.

23. **Commitment:** 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.

    Timing: Immediate upon closing of the merger and ongoing.

    Amount: No cost.

    Metric: Easily verifiable.

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

    Timing: Immediate upon closing of the merger and ongoing.

    Amount: No cost.

    Metric: Easily verifiable.

25. **Commitment:** 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.

Timing: Every 3 years, starting within the first full fiscal year.

Amount: Costs of recruitment related to implementation of the recruitment plan shall be part of the $140 million commitment referenced below in number 26. Expenditures incurred in the development of the community needs assessment and the recruitment plan shall not be credited toward that $140 million commitment.

Metric: Credible evidence of recruitment plan, which identifies needs and priorities. The first community needs assessment and physician/physician extender recruitment plan shall be presented to the Commissioner no later than in the annual report submitted after the end of the first full fiscal year after closing of the merger, and thereafter at three (3) year intervals (or more frequently if the plan is amended). In each annual report, the New Health System shall report on progress toward its recruitment goals including the number of recruited physicians by specialty, and related data such as recruitment efforts, interviews conducted, and the number of offers extended. To the extent that physician needs identified in the plan are not met in 600 days or more (measured at the end of each full fiscal year), the New Health System shall include an explanation of the feasibility of meeting the plan for the unfilled position(s), additional steps, if any, that management believes are appropriate to take, and consideration of alternatives such as building relationships with centers of excellence to improve the availability of the missing specialty to patients in the region. In order to preserve competition, this annual reporting requirement will be treated as confidential.

26. **Commitment:** Enhancing healthcare services:
    a. In an effort to enhance treatment of substance abuse in the region, the New Health System will create new capacity for residential addiction recovery services serving the people of Southwest Virginia and Tennessee.
    b. Because improved mental health services is a priority of the Authority and the law, the New Health System will develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements throughout the Virginia and Tennessee service area.
    c. As part of the priority of preserving hospital services in geographical proximity to the communities traditionally served by the facilities, and to ensure access to care, the New Health System will develop pediatric specialty centers and Emergency Rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting in close proximity to patients' homes.

Timing: The plan will be developed no later than 24 months after closing and will include a time schedule for implementing the plan and expenditures under the plan.

Amount: $140 million over 10 years including physician recruitment referenced in number 25 above.

Metric: The New Health System will include in the annual report for the second full fiscal year the plan for enhancing healthcare services, and in that report and each following, shall include in the annual report progress in implementing the plan and expenditures made.

27. **Commitment:** In an effort to enhance population health status consistent with the regional health goals established by the Authority, the New Health System will invest not less than $75 million over ten years in population health improvement for the service area. The New Health System will establish a plan, to be updated annually in collaboration with the Authority, the Commonwealth, and possibly the State of Tennessee, to make investments that are consistent with the plan and to complement resources already being expended. The New Health System also commits to pursuing opportunities to establish Accountable Care Communities in partnership with various local, state and federal agencies, payers, service providers and community groups who wish to partner in such efforts. It is the desire of the New Health System for the Commonwealth and Tennessee to collaborate with the New Health System to establish a regional plan that disregards state boundaries.

    Timing: 10 years.

    Amount: $75 million.

    Metric: The New Health System will establish and track long-term outcome goals similar to those developed in Healthy People 2020 and consistent with the health plans of Virginia and Tennessee, and will be evaluated based on whether expenditures made are consistent with the plan established by the collaborative between the states, including the Authority, and the New Health System.

    Discussion: The expenditures of $75 million throughout the region have the greatest positive impact only if those dollars are spent in a prioritized way in collaboration with the state health plan and the regional priorities as established by the Authority, and in partnership with efforts already underway through community based assets.

28. **Commitment:** In support of the Authority's role in promoting population health improvement under the Commonwealth's Cooperative Agreement with the New Health System, the New Health System shall reimburse the Authority for costs associated with the various planning efforts cited above in an amount up to $75,000 annually, with CPI increases each year. No reimbursable costs shall be paid toward compensation for any member of the Authority's Board or Directors.

    Timing: Annual.

    Amount: Up to $75,000 annually as part of the $75 million for population health improvement, with annual CPI increases.

    Metric: Reimbursement is made or is not made. All amounts paid to the Authority shall be included in the annual report submitted to the Commissioner.

29. **Commitment:** Best practice governance of the New Health System is critical to the success of the efforts outlined in the Cooperative Agreement. As such, the Board of Directors of the New Health System will operate such that each Board member must exercise the Duty of Care, Loyalty and Obedience to the New Health System required by law, and all Board members must adhere to the strict fiduciary policies established by the Board. It is recognized that governance of the New Health System should reflect the region, including both Virginia and Tennessee. As such, the New Health System makes the following commitments related to governance:
    - Currently, one member of the Board of Directors resides in Virginia. No later than 3 months after closing, an additional resident of Virginia will be appointed to serve on the Board of Directors of the New Health System. Such resident shall be appointed through the governance selection process outlined in the bylaws of the New Health System;
    - The New Health System will ensure membership from Virginia on the following Board committees, with full voting privileges: Finance, Audit and Compliance, Quality, Community Benefit/Population Health, and Workforce;
    - The New Health System will ensure than not less than 30 percent of the composition of the Community Benefit/Population Health committee will reside in Virginia (committee will be the Board committee responsible for the oversight of the compliance of the Cooperative Agreement); and
    - Within 5 years, not less than 3 members of the Board of Directors will reside in the Commonwealth of Virginia, and such composition shall be sustained.

    Timing: Ongoing.

    Amount: No dollar cost.

    Metric: Easily verifiable.

30. **Commitment:** The New Health System expects that the conditions under which the Cooperative Agreement is granted will be enumerated in a formal enforceable agreement between the New Health System and the Commissioner, and it is expected an annual report will be required. Any report will be attested to by the appropriate leadership of the New Health System, including the Senior Executive.

    Timing: Annual.

    Amount: No material cost.

    Metric: Receipt of compliant report.

31. **Commitment:** The New Health System will provide information on a quarterly basis of the key financial metrics and the balance sheet comparing performance to the similar prior year period and year to date. This information will be provided on the same timetable as what is publicly reported through EMMA (Electronic Municipal Market Access).

    Timing: Annual and quarterly.

    Amount: No material cost.

Metric: Easily verified.

32. **Commitment:** The New Health System will adhere to Exhibit 12.1 setting forth relevant considerations and the process for closing a facility should it be necessary. This policy will remain in effect unless the change is agreed to by the Commissioner.

    Timing: If closing a facility is considered.

    Amount:

    Metric: Annual report will provide evidence of compliance with policy.

33. **Commitment:** The New Health System shall create, together with the Southwest Virginia Health Authority, a Joint Task Force comprised of four members, two from the New Health System and two from the Southwest Virginia Health Authority. The Task Force shall meet at least annually to guide the collaboration between the Authority and the New Health System, and to track the progress of the New Health System toward meeting the commitments of the Cooperative Agreement and shall report such progress to the Authority. The Task Force shall be chaired by a member of the Authority. The members appointed by the Authority may not have a conflict of interest.

    Timing: Immediate upon closing of the merger.

    Amount: No cost.

    Metric: Creation of a Joint Task Force.

A. Revision of Commitments – Recommendations by the Authority to the Commissioner

These commitments have been negotiated and drafted with the intent of them remaining in place for ten (10) years. Nevertheless, there may be changes in circumstances that arise which affect the feasibility or the meaningfulness of the commitments and which are not possible to foresee presently. For example,[5] a major structural change to the federal payment system could, depending on how it is implemented, materially change both the needs of the region and the New Health System's ability to meet those needs. Other events which may have a material effect include, but are not limited to, substantial and material reductions in federal reimbursement, repeal of Certificate of Public Need, labor shortages causing significant and material increases in labor expense, significant reductions in inpatient hospital use rates which cause a material decrease in revenue (and which may be demonstrated to reduce the total cost of care), or an act of God. It is the interest of the Commonwealth that the region's hospitals maintain their financial viability, that they are of sound credit worthiness and that they are

[5] These are examples only and are not intended to be exclusive basis for amending the agreement, but simply as an illustration of a possible change in circumstances that may have a material impact.

capable of reinvesting capital. Accordingly, if the New Health System produces clear and convincing evidence that changes in circumstances have materially affected its ability to meet the commitments and that its inability is not affected by deficiencies in management, either the Commissioner or the New Health System may petition the other to amend the commitments to reduce the burden or cost of the commitments to a level that may be more sustainable. In the event that the New Health System petitions the Commissioner for amendment of the Cooperative Agreement, the Commissioner may require the New Health System to engage an independent consultant to prepare a report validating that the changes in circumstances have adversely affected the New Health System, the extent to which this has occurred, and validating that the changes in circumstances are not related to the effectiveness of management. The cost of such an independent consultant engagement shall not exceed $250,000 (as adjusted by the CPI from the date of the closing of the merger). The amendment process should not be used to increase the overall level of burden or cost on the New Health System, although the parties acknowledge that depending on the change in circumstance, measuring the change in the level of burden or cost may be subject to reasonable ranges and disagreement of the impact within a range. If either party petitions for amending the commitments and the parties cannot come to agreement, the parties shall agree on a dispute resolution process in order to reach agreement.

B. Ten-Year Review of Cooperative Agreement – Recommendations by the Authority to the Commissioner

Before the end of calendar year 2026, the New Health System and the Commissioner shall review how well the formation and operation of the New Health System has served the overall interests of Virginians and Virginia businesses in the area. That review will consider all the elements set forth in Section 15.2-5384.1, Code of Virginia, and will also consider New Health System's profitability. It is the opinion of the Authority that the citizens of the region and the Commonwealth are well-served when the health system generates the resources necessary to be sustainable, of good credit, and capable of meeting its commitments as a community-based health system in the region. It is the hope of the Authority that the New Health System achieves financial sustainability that exceeds national or regional averages. If, however, it appears the New Health System is generating excessive profits and negotiated payment rates to the New Health System have increased more rapidly than national or regional averages, new or additional commitments may be appropriate. Conversely, if the New Health System is unable to attain sufficient profitability notwithstanding effective management, reducing the burden of the commitments would be appropriate. Likewise, if the New Health System is not maintaining its support of population health, subsidizing money-losing services, medical education, research, and physician recruitment, new commitments may be appropriate. In the event that an extension of the existing cooperative agreement or negotiation of a new or amended agreement is not achieved, the Commonwealth should withdraw its support for the cooperative agreement.