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January 31, 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 # 7

Dear Mr. Bodin,

Response # 7 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 # 7:

Section V. Additional Information

N. Market Analysis
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Q. Regional Exchange of Health Information an Information Systems
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T. Additional Information
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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,

Francis C. Oroszlan

cc: Peter Boswell
Allyson K. Tysinger

867247/1

RESPONSE #7

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 31, 2017

V.N.1.

N. Market Analysis

1. The identity of any Party hospital located in the PSA and SSA and any Party hospital outside of the PSA and SSA that also serves patients in the Parties' PSA and SSA, regardless of state.

JOINT RESPONSE: The Parties believe that the Geographic Service Area encompassing the 21-county area in Southwest Virginia and Northeast Tennessee outlined in the Application accurately reflects the Applicants' current and predicted future service areas. The Geographic Service Area reflects the service area over which the Applicants intend to develop a fully integrated health care delivery system with supporting infrastructure, and is the area currently served by the Applicants. As noted by the Parties in Response 10 to the Southwest Virginia Response, ninety-eight percent (98%) of the NHS's combined patient discharges come from the Geographic Service Area - the 21 counties in Virginia and Tennessee. The Applicants do not expect the New Health System's service area to differ from this 21-county area.

In response to the specific request to identify the Party hospitals located in the primary and secondary service area using the 75% and 90% methodology, as defined by guidance from the Authority, **Exhibit N-1A** contains a map that shows the locations of the Parties' hospitals as well as other area hospitals and demonstrates whether they fall within the New Health System's PSA or SSA. Mountain States hospitals are labeled in orange while Wellmont hospitals are labeled in purple. Mountain States and Wellmont have no hospitals outside of Virginia and Tennessee.[1] The map was created using the New Health System's discharge data for CY2014 to identify the zip codes that constitute both the 75% and 90% service areas for the New Health System based on the combined discharges of Mountain States and Wellmont. Below the map in **Exhibit N-1A** is a table listing each of the Parties' hospitals along with whether the hospital is located physically in the Parties' PSA or SSA. **Exhibit N-1B** is a table supporting **Exhibit N-1A**, and it lists the zip codes that make up the 75% and 90% service areas for the New Health System along with the Mountain States and Wellmont discharges, respectively, for the zip codes that constitute each of their 75% and 90% service areas defined using the Authority's guidance.

INDEX OF DOCUMENTS:

- Exhibit N-1A Map of Hospitals In and Out of 75% and 90% Service Areas
- Exhibit N-1B Zip Codes of 75% and 90% Service Areas

[1] Takoma Regional Hospital was not considered one of the Parties' hospitals when determining the service areas, but note that it has since been acquired by Wellmont as of December 31, 2016..

V.O.15.

15. In the event that the merger is unwound due to unanticipated negative effects, and the plan of separation needs to be implemented, how do the applicants plan to maintain the smooth operation of the affected hospitals and facilities within the merged system, and prevent undue disruption so that existing access to health care services continues to be maintained? Will such a plan have a Virginia-specific component?

JOINT REPSONSE: Since announcing the merger agreement in April, 2015, WHS and MSHA have maintained the independent operations of each respective system while also planning for the merger. If the merger is "unwound" due to unanticipated negative effects, we will similarly manage the process while concurrently maintaining operations of all entities. If facilities or business units are required to be spun off or divested, those entities will be treated as continuing operations until such time as the spin off or divestiture is closed. There would be no disruption in services during the transition period. In the event of a required separation of the Virginia cooperative agreement, all of the NHS's Virginia facilities and operations would be evaluated and subject to the Plan of Separation.

Since submitting the Application in February 2016, the Parties revised the initial Plan of Separation (submitted as Application Exhibit 18.1) to provide additional details to specifically address how the separation would be handled in the first 18 months after closing (the "Short-Term Period") and afterward (the "Long-Term Period"). This revised Virginia Plan of Separation is attached hereto as **Exhibit O-15**. The goal of the Short-Term Period Plan is to re-establish a competitive dynamic by returning assets and operations to the control of the contributing party. Details of the Short-Term Period Plan address: restriction on the transfer of assets during the Short-Term Period, governance, management, financial matters (such as debt and reserves), employees, employee benefits, clinical services, information technology, payers, physicians, and dissolution of the NHS. The Short-Term Period Plan contemplates that Virginia facilities would be transferred back to the Party that owned them prior to the cooperative agreement, in the same way that Tennessee facilities would be.

Similar detail is not possible for a Long-Term Period Plan because of the lack of ability to predict the health care environment that would exist at the time of a separation farther in the future. The Long-Term Period Plan lays out the process that would be followed to bring about the separation in an orderly way and to minimize the disruption in services during the transition.

As required by the Cooperative Agreement Statute, the Commissioner will maintain active, ongoing supervision of the Cooperative Agreement, which will provide a continuing mechanism for evaluation of the Cooperative Agreement. As part of the Commissioner's active supervision, there are also three mechanisms available to modify the Cooperative Agreement where warranted in lieu of the dire step of a separation. These modification mechanisms are set forth in Authority recommendations to the Commissioner and in the Cooperative Agreement Statute.

1. Adjustments at Ten-Year Review of Cooperative Agreement. In the Authority Report, the Authority recommends a ten-year review of the Cooperative Agreement by the Commissioner and the New Health System. It is the intention of the Authority and the Applicants that the Cooperative Agreement remain in place beyond the 10-year period to ensure continuing public advantage for the region, and the review is simply intended to account for adjustments that

may be needed after the first ten years and to reflect on the long-term success of the Cooperative Agreement. The Parties believe the Cooperative Agreement is poised to become a long-term solution for the unique, challenging health care issues facing Southwest Virginia. The Authority's recommendation is:

> 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.[103]

2. Significant, Unforeseen Change in Circumstances at Any Time. Further, in conjunction with the Parties' revised Commitments, the Authority has recommended to the Commissioner in the Authority Report a new provision to be part of the Cooperative Agreement that would address unanticipated changes in circumstances during the interim of the ten-year period that would allow revision of the commitments and Cooperative Agreement in lieu of separation in warranting circumstances.[104] The Authority's recommendation is:

> 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,[105] a major

[103] See Authority Report, pages 150-151, and also NHS Revised Commitments set forth in Exhibit G-1A.
[104] See Exhibit G-1A.
[105] 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.

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 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.[106]

3. Action by Commissioner to Determine Compliance with the Cooperative Agreement Statute. The Cooperative Agreement Statute provides a mechanism to alter the cooperative agreement if the Commissioner should have reason at any time to believe that compliance with the cooperative agreement is falling short of the standards set forth in the Statute.[107] In such case, the Parties anticipate that the Commissioner would initiate a proceeding to determine compliance, as provided in the Cooperative Agreement Statute and Regulations.[108] This would enable the Commissioner to seek reasonable modifications, with the consent of the NHS, to the cooperative agreement,[109] thereby eliminating the need for a separation. The following is the provision from the Cooperative Agreement Statute:

[106] See Authority Report, page 150, and also NHS Revised Commitments set forth in Exhibit G-1A
[107] Virginia Code § 15.2-5384.1.H.
[108] Virginia Code § 15.2-5384.1.H and 12VAC5-221-130.A.
[109] 12VAC5-221-130.B.

> Virginia Code Section 15.2-5384.1.H.
>
> If the Commissioner has reason to believe that compliance with a cooperative agreement no longer meets the requirements of this chapter, the Commissioner shall initiate a proceeding to determine whether compliance with the cooperative agreement no longer meets the requirements of this chapter. In the course of such proceeding, the Commissioner is authorized to seek reasonable modifications to a cooperative agreement, with the consent of the parties to the agreement, in order to ensure that it continues to meet the requirements of this chapter. The Commissioner is authorized to revoke a cooperative agreement upon a finding that (i) the parties to the agreement are not complying with its terms or the conditions of approval; (ii) the agreement is not in substantial compliance with the terms of the application or the conditions of approval; (iii) the benefits resulting from the approved agreement no longer outweigh the disadvantages attributable to the reduction in competition resulting from the agreement; (iv) the Commissioner's approval was obtained as a result of intentional material misrepresentation to the Commissioner or as the result of coercion, threats, or intimidation toward any party to the cooperative agreement; or (v) the parties to the agreement have failed to pay any required fee. All proceedings initiated by the Commissioner under this chapter and any judicial review thereof shall be held in accordance with and governed by the Virginia Administrative Process Act (§ 2.2-4000 et seq.).

Notwithstanding the ability to modify the cooperative agreement, if a separation were required during the (1) Short-Term Period, the Parties would implement the detailed process outlined in the Plan of Separation, and (2) Long-Term Period, the Parties would work with the Commissioner to determine the appropriate way to effectuate an orderly transition in accordance with the Plan of Separation developed by the Parties, including provision for any Virginia-specific details that may be warranted.

INDEX OF DOCUMENTS:

- Exhibit O-15 Revised Virginia Plan of Separation

V.Q.15.

15. Provide estimates for how and when the $150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated, including but not limited to the amount designated for the Common Clinical IT Platform, the amount designated for connectivity with non-System providers, and population health management and quality reporting capabilities. If relevant, provide estimated costs to offer EHR solutions for non-System providers, and estimated expenses to support connectivity for non-System providers, along with estimates for any revenue projected to be realized from any services offerings related to these capabilities.

JOINT RESPONSE: **Exhibit Q-2C** provides substantial detail on the NHS's comprehensive approach for information technology integration, which will enable it to transform from traditional fee-for-service to value-based population health. The following general timeline

NHS anticipates the following timeline for the $150 million investment in a Common Clinical IT Platform:

1. No later than six months after closing, NHS will have completed a comprehensive implementation plan for its investment in a Common Clinical IT Platform, including the estimated total costs and timeline. NHS's original and current estimates for the total costs of this plan were $150 million.
2. NHS has committed to implement the Common Clinical IT Platform no later than 48 months after closing.[123]
3. At this time, NHS does not have any information about the estimated costs to offer EHR solutions for non-system providers, the estimated expenses to support connectivity for non-system providers, and the estimated revenue projected to be realized from any service offerings related to these capabilities.

See **Exhibit 2-QA** for more information on a high-level timeline for how and when the $150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated.

[123] See Revised Commitment 19, **Exhibit G-1A**.

V.T.33.

33. Provide a copy of the full response MSHA sent to any request for proposals, or similar request, issued by WHS in or about 2014 related to their interest in engaging in a merger, acquisition, contract management or other such arrangement.

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibit T-33** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit T-33 MSHA Response to WHS Request for Proposal– **PROPRIETARY**

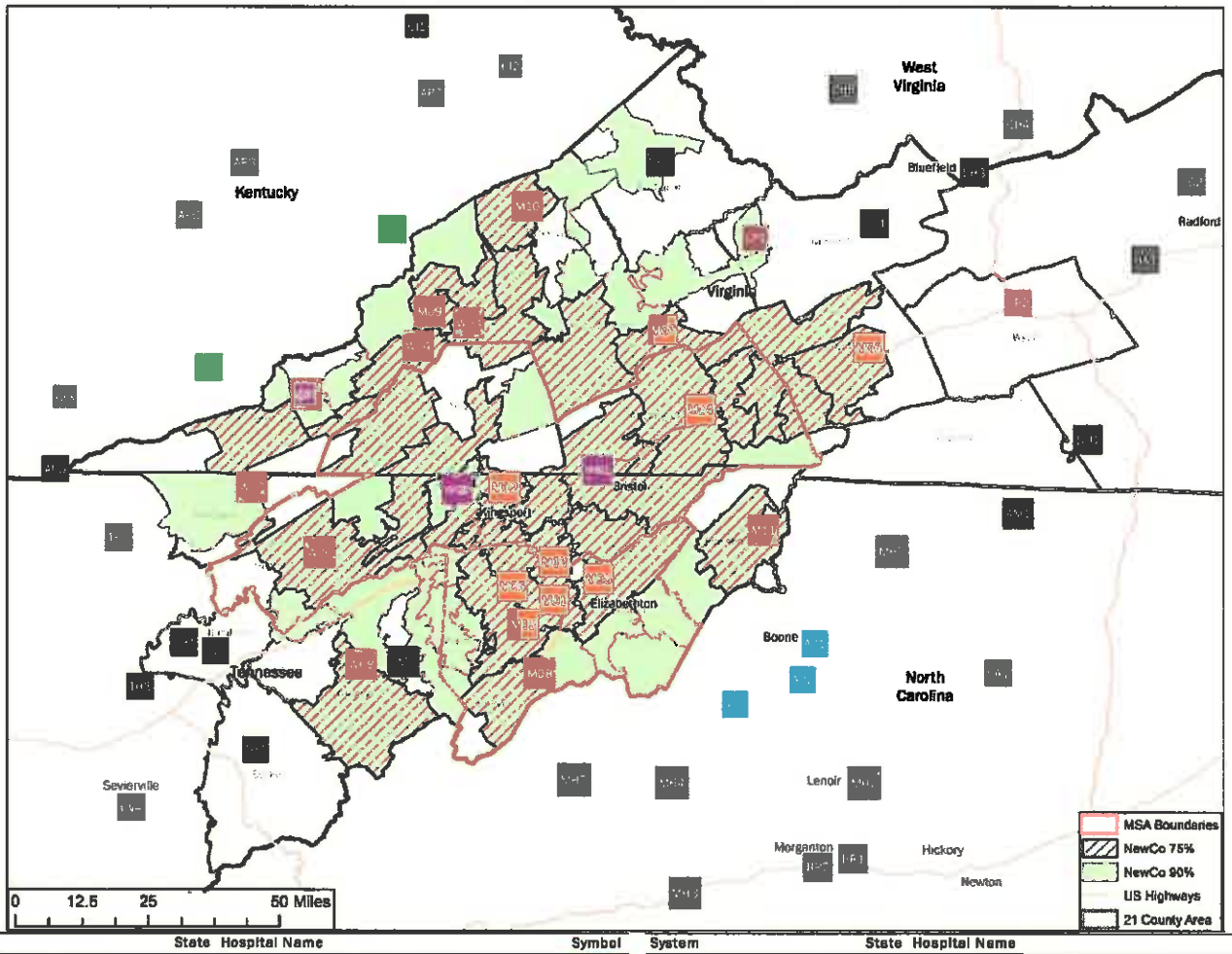
LIST OF EXHIBITS FOR RESPONSE #7

SECTION V

Exhibit Number	Description
N-1A	Map of Hospitals In and Out of 75% and 90% Service Areas
N-1B	Zip Codes of 75% and 90% Service Areas
O-15	Revised Virginia Plan of Separation
T-33	MSHA Response to WHS Request for Proposal ***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 N-1A. 75% (PSA) and 90% (SSA) Service Areas (Map) Based on New Health System Discharges

(Mountain States + Wellmont)



System	State	Hospital Name	Symbol
Mountain States Health Alliance	TN	Johnson City Medical Center	M01
	TN	Indian Path Medical Center	M02
	VA	Smyth County Community Hospital	M03
	VA	Johnston Memorial Hospital	M04
	TN	Franklin Woods Community Hospital	M05
	TN	Sycamore Shoals Hospital	M06
	VA	Russell County Medical Center	M07
	TN	Unicoi County Memorial Hospital	M08
	VA	Norton Community Hospital	M09
	VA	Dickenson Community Hospital	M10
	TN	Johnson County Community Hospital	M11
	TN	Woodridge Hospital	M12
	TN	Quillen Rehabilitation Hospital***	M13

System	State	Hospital Name	Symbol
Wellmont Health System	TN	Wellmont Bristol Regional Medical Center	W01
	TN	Wellmont Holston Valley Medical Center	W02
	VA	Mountain View Regional Medical Center	W03
	VA	Wellmont Lonesome Pine Hospital	W04
	VA	Lee Regional Medical Center *(Closed)* *	W05
	TN	Wellmont Hawkins County Memorial Hospital	W06
	TN	Wellmont Hancock County Hospital	W07
	TN	Takoma Regional Hospital *(Independent)* **	W08

**The data provided include Takoma Regional Hospital as an independent hospital. Wellmont's acquisition of Takoma Regional Hospital, located in Greene County, Tennessee, was recently completed on December 31, 2016.

PARTY HOSPITAL	Party	PSA or SSA
WELLMONT HANCOCK COUNTY HOSPITAL	Wellmont	SSA
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	Wellmont	PSA
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	Wellmont	PSA
WELLMONT LONESOME PINE HOSPITAL	Wellmont	PSA
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	Wellmont	PSA
WELLMONT HOLSTON VALLEY MEDICAL CENTER	Wellmont	PSA
TAKOMA REGIONAL HOSPITAL	Wellmont	PSA
DICKENSON COMMUNITY HOSPITAL	Mountain States	PSA
JOHNSON COUNTY COMMUNITY HOSPITAL	Mountain States	PSA
QUILLEN REHABILITATION HOSPITAL	Mountain States	PSA
UNICOI COUNTY MEMORIAL HOSPITAL	Mountain States	PSA
SMYTH COUNTY COMMUNITY HOSPITAL	Mountain States	PSA
RUSSELL COUNTY MEDICAL CENTER	Mountain States	PSA
NORTON COMMUNITY HOSPITAL	Mountain States	PSA
SYCAMORE SHOALS HOSPITAL	Mountain States	PSA
WOODRIDGE PSYCHIATRIC HOSPITAL	Mountain States	PSA
FRANKLIN WOODS COMMUNITY HOSPITAL	Mountain States	PSA
INDIAN PATH MEDICAL CENTER	Mountain States	PSA
JOHNSTON MEMORIAL HOSPITAL	Mountain States	PSA
JOHNSON CITY MEDICAL CENTER	Mountain States	PSA

Exhibit N-1B. 75% and 90% Service Areas (Zip Codes) Based on New Health System Discharges (Mountain States + Wellmont)

ZIP Code	Discharges	Percentage of Total	Cumulative	75% Service Area	90% Service Area
37660	5,182	5.8%	5.8%	x	x
37601	5,138	5.8%	11.6%	x	x
37643	4,943	5.6%	17.2%	x	x
37620	4,127	4.6%	21.8%	x	x
37604	3,947	4.4%	26.3%	x	x
37659	3,099	3.5%	29.7%	x	x
37664	2,811	3.2%	32.9%	x	x
24210	2,333	2.6%	35.5%	x	x
24201	2,242	2.5%	38.0%	x	x
37857	2,193	2.5%	40.5%	x	x
24354	2,170	2.4%	43.0%	x	x
37650	1,948	2.2%	45.1%	x	x
37615	1,945	2.2%	47.3%	x	x
37642	1,660	1.9%	49.2%	x	x
24219	1,532	1.7%	50.9%	x	x
37617	1,491	1.7%	52.6%	x	x
24293	1,390	1.6%	54.2%	x	x
24202	1,336	1.5%	55.7%	x	x
37683	1,335	1.5%	57.2%	x	x
37618	1,335	1.5%	58.7%	x	x
24266	1,332	1.5%	60.2%	x	x
24230	1,276	1.4%	61.6%	x	x
37663	1,251	1.4%	63.0%	x	x
24211	1,069	1.2%	64.2%	x	x
24273	1,030	1.2%	65.4%	x	x
24251	990	1.1%	66.5%	x	x
24319	985	1.1%	67.6%	x	x
24228	917	1.0%	68.6%	x	x
24370	911	1.0%	69.7%	x	x
37743	895	1.0%	70.7%	x	x
24340	844	0.9%	71.6%	x	x
24244	772	0.9%	72.5%	x	x
24224	749	0.8%	73.3%	x	x
24263	740	0.8%	74.2%	x	x
37686	731	0.8%	75.0%	x	x
24361	684	0.8%	75.7%	x	x
37665	679	0.8%	76.5%		x
24277	675	0.8%	77.3%		x
37692	665	0.7%	78.0%		x
37745	661	0.7%	78.8%		x
24260	660	0.7%	79.5%		x
24279	659	0.7%	80.2%		x
37681	640	0.7%	81.0%		x
37658	613	0.7%	81.7%		x
37687	534	0.6%	82.3%		x
37641	494	0.6%	82.8%		x
37645	491	0.6%	83.4%		x
24236	461	0.5%	83.9%		x
24283	455	0.5%	84.4%		x
37873	449	0.5%	84.9%		x
37690	448	0.5%	85.4%		x
37640	427	0.5%	85.9%		x
24216	411	0.5%	86.3%		x
37869	369	0.4%	86.8%		x
37656	343	0.4%	87.1%		x
24609	322	0.4%	87.5%		x
24243	317	0.4%	87.9%		x
24237	296	0.3%	88.2%		x
24256	277	0.3%	88.5%		x
24271	273	0.3%	88.8%		x
37711	272	0.3%	89.1%		x
24290	245	0.3%	89.4%		x
24614	238	0.3%	89.7%		x
24641	236	0.3%	89.9%		x
24225	230	0.3%	90.2%		x

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

Pursuant to Approval of the Cooperative Agreement Application
By the Virginia State Health Commissioner

This Revised Plan of Separation ("the Revised Plan") is prepared as part of the application for Cooperative Agreement submitted jointly by Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States," and collectively with Wellmont "the Parties") submitted to the Southwest Virginia Health Authority and the Virginia State Health Commissioner ("the Commissioner"). The Revised Plan is intended to set out the process by which the Parties would effect an orderly separation of the new, integrated health system to be created under the Cooperative Agreement (the "New Health System") in the event that the Commissioner determines that it is necessary to terminate the Cooperative Agreement previously granted to the Parties, as set forth in Virginia Code Section 15.2-5384.1(H).

1. Overview. The purpose of this outline is to comply with Virginia Code Section 15.2-5384.1. The Revised Plan will be described in two scenarios: the "Short-Term Period" (0 to 18 months) and the "Long-Term Period" (after 18 months).

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

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

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

   C. The Process. Upon written notice from the Commissioner that the Cooperative Agreement has been terminated, the following would occur:

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

      (2) Governance. The New Health System's Board of Directors will oversee the plan of separation to insure that the plan is successfully implemented,

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

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

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

(3) Management.

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

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

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

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

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

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

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

(5) Employees. The New Health System employees will be assigned to their principal place of business. Clinical employees will be assigned to the Mountain States/Wellmont site that is the employee's principal place of service.

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

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

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

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

(10) Physicians. During the Short-Term Period, the New Health System expects to plan, but not execute, a combination of its physician enterprises. To the extent any physician services are combined, a plan of separation addressing physician services, including actions to return physician and other clinic employees to the Mountain States or Wellmont entity that was

his or her employer at the closing, will be submitted to the Commissioner for information prior to action. Hospital-based physician contracts, such as radiology, pathology, anesthesia, hospitalists, and emergency medicine shall be assigned to the site of service. Mountain States and Wellmont shall honor the physician contracts for the remainder of the base terms (without renewals).

(11) Dissolution. Once Mountain States and We1lmont no longer require support services from the New Health System, the Board of Directors of the New Health System will follow the procedures for voluntary dissolution of the New Health System as provided by Virginia law.

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

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

B. The Process:

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

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

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

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

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

D. The Final Plan will provide that the Commissioner may require that an independent third-party health care expert serve as a monitor ("the Monitor") to oversee the process of implementing the Final Plan. The New Health System will pay the fees and expenses of the Monitor.

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